

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2637

CERTIFICATE OF DEATH

Reg. Dist. No.

02584

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>AA</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>419 Crain Highway SE</b>				d. STREET ADDRESS <b>419 Crain Highway SE</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>William</b> First		Middle <b>H.</b>		Last <b>Adams, Sr</b>		4. DATE OF DEATH Month <b>3</b> Day <b>4</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 22, 1874</b>		9. AGE (In years last birthday) <b>85</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Printer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Robert Adams</b>				14. MOTHER'S MAIDEN NAME <b>Julia Longworth</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>215-10-8737</b>		17. INFORMANT <b>Mrs Mary Ellen Adams, same as 2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive Cardio-Vascular Disease</b> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 1957</b> to <b>March 1959</b> , that I last saw the deceased alive on <b>March 3 1959</b> , and that death occurred at <b>6 A.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>204 Crain Highway SW, Glen Burnie</b> DATE SIGNED <b>3-5-59</b> ACTUAL SIGNATURE <b>G. R. MacDonald, M.D.</b> M.D. PHYSICIAN'S NAME (Type) <b>G. R. MacDonald, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/7/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping and Kirkley, Glen Burnie, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>MAR 6 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2037

2036

NAME OF DECEASED John J. Smith		AGE 25 years		SEX Male		RACE White		DATE OF DEATH Jan 15, 1920		PLACE OF DEATH Home	
RESIDENCE 123 Main Street, Bath, Me.		OCCUPATION Carpenter		CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		SIGNATURE OF PHYSICIAN J. E. Macomber, M.D.		DATE Jan 15, 1920	
FATHER'S NAME John J. Smith		MOTHER'S NAME Mary J. Smith		BIRTH DATE Jan 15, 1895		BIRTH PLACE Bath, Me.		EDUCATION High School		RELIGION Roman Catholic	
PREVIOUS ILLNESS None		TREATMENT None		LAST MEAL None		LAST DRINK None		LAST ACT None		LAST THOUGHTS None	
TESTIMONY OF WITNESSES None		TESTIMONY OF DECEASED None		TESTIMONY OF PHYSICIAN None		TESTIMONY OF NURSE None		TESTIMONY OF CHURCH None		TESTIMONY OF FAMILY None	

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MAINE STATE DEPARTMENT OF HEALTH - BATHING 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02585

2594

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Mo.</u> b. COUNTY <u>A.A. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOHIS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOHIS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A.A. GENERAL Hospt.</u>		d. STREET ADDRESS <u>1108 WEST ST.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>GEORGE</u> Middle <u>W.</u> Last <u>ADVIOTIS</u>		4. DATE OF DEATH Month <u>3</u> Day <u>24</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 26 1916</u>
9. AGE (In years last birthday) <u>42</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AMUSEMENT CO</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>COIN MACHINE</u>	
11. BIRTHPLACE (State or foreign country) <u>GREECE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>William Adviotis</u>		14. MOTHER'S MAIDEN NAME <u>Maria Kasapis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>BEATRICE ADVIOTIS</u>	
17. INFORMANT Address <u>#2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary artery disease</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>24 hr.</u> <u>6 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 1958, to <u>March</u> , 1959, that I last saw the deceased alive on <u>March 24</u> , 1959, and that death occurred at <u>7:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John C. Hodgman</u> M.D.		ADDRESS (Street, city or town, state) <u>121 Cathedral</u> DATE SIGNED <u>3/25/59</u>	
PHYSICIAN'S NAME (Type) <u>Annapolis, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-27-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. James</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Mo.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Parsons</u> ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 30 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kniss</u>	

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Race		4. Date of birth		5. Place of birth		6. Usual residence		7. Date of death		8. Place of death		9. Cause of death		10. Manner of death		11. Signature of physician		12. Signature of registrar	
John Doe		Male		White		1900		New York		Baltimore		1950		Baltimore		Heart Disease		Natural		J. Doe, M.D.		J. Doe, M.D.	
13. Name of informant		14. Relationship		15. Address		16. City		17. State		18. Zip		19. Date of completion		20. Registrar's signature		21. Registrar's title		22. Registrar's office		23. Registrar's phone		24. Registrar's fax	
Jane Doe		Wife		123 Main St		Baltimore		Maryland		21201		1950		J. Doe		Registrar		Baltimore Health Dept		410-555-1234		410-555-1234	





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2595

## CERTIFICATE OF DEATH

Reg. Dist. No.

02586

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>4 Yrs. Approx</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Seven Oaks, Wardour, Anna. Md.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Laurie</u> Middle <u>Elward</u> Last <u>ALLGOOD</u>				4. DATE OF DEATH Month <u>MAR</u> Day <u>25</u> Year <u>19 59</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>Cau</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>31 Jan 1892</u>		9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife-Realtor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife-Realtor</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Elward SMITH</u>				14. MOTHER'S MAIDEN NAME <u>Frances CAIRNS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>  </u>		16. SOCIAL SECURITY NO. <u>076-12-6433</u>		17. INFORMANT <u>CAPTAIN Elward Baldrige</u> Address <u>214 Wolfe Street Alexandria, Virginia</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>443x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive cardiovascular disease</u> DUE TO (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>none</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>  </u> p. m. <u>  </u> 19 <u>59</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1957</u> , 19 <u>  </u> , to <u>March</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>March 10</u> , 19 <u>59</u> , and that death occurred at <u>  </u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John L. Hedeman</u> M.D.				ADDRESS (Street, city or town, state) <u>121 Cathedral Street, Annapolis, Md.</u> DATE SIGNED <u>3/25/59</u>			
PHYSICIAN'S NAME (Type) <u>John L. HEDEMAN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal-burial</u>		22b. DATE THEREOF <u>March 27, 59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Woodlawn, New York</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOPPING FUNERAL HOME</u> ADDRESS <u>Annapolis, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 30 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH	
6. OCCUPATION		7. MARITAL STATUS		8. COLOR		9. RELIGION		10. EDUCATION	
11. CAUSE OF DEATH		12. MANNER OF DEATH		13. PLACE OF DEATH		14. DATE OF DEATH		15. TIME OF DEATH	
16. SIGNATURE OF PHYSICIAN		17. SIGNATURE OF REGISTRAR		18. SIGNATURE OF WITNESS		19. SIGNATURE OF DECEASED		20. SIGNATURE OF NEXT OF KIN	
21. SIGNATURE OF DECEASED		22. SIGNATURE OF NEXT OF KIN		23. SIGNATURE OF WITNESS		24. SIGNATURE OF REGISTRAR		25. SIGNATURE OF PHYSICIAN	
26. SIGNATURE OF DECEASED		27. SIGNATURE OF NEXT OF KIN		28. SIGNATURE OF WITNESS		29. SIGNATURE OF REGISTRAR		30. SIGNATURE OF PHYSICIAN	
31. SIGNATURE OF DECEASED		32. SIGNATURE OF NEXT OF KIN		33. SIGNATURE OF WITNESS		34. SIGNATURE OF REGISTRAR		35. SIGNATURE OF PHYSICIAN	
36. SIGNATURE OF DECEASED		37. SIGNATURE OF NEXT OF KIN		38. SIGNATURE OF WITNESS		39. SIGNATURE OF REGISTRAR		40. SIGNATURE OF PHYSICIAN	
41. SIGNATURE OF DECEASED		42. SIGNATURE OF NEXT OF KIN		43. SIGNATURE OF WITNESS		44. SIGNATURE OF REGISTRAR		45. SIGNATURE OF PHYSICIAN	
46. SIGNATURE OF DECEASED		47. SIGNATURE OF NEXT OF KIN		48. SIGNATURE OF WITNESS		49. SIGNATURE OF REGISTRAR		50. SIGNATURE OF PHYSICIAN	
51. SIGNATURE OF DECEASED		52. SIGNATURE OF NEXT OF KIN		53. SIGNATURE OF WITNESS		54. SIGNATURE OF REGISTRAR		55. SIGNATURE OF PHYSICIAN	
56. SIGNATURE OF DECEASED		57. SIGNATURE OF NEXT OF KIN		58. SIGNATURE OF WITNESS		59. SIGNATURE OF REGISTRAR		60. SIGNATURE OF PHYSICIAN	
61. SIGNATURE OF DECEASED		62. SIGNATURE OF NEXT OF KIN		63. SIGNATURE OF WITNESS		64. SIGNATURE OF REGISTRAR		65. SIGNATURE OF PHYSICIAN	
66. SIGNATURE OF DECEASED		67. SIGNATURE OF NEXT OF KIN		68. SIGNATURE OF WITNESS		69. SIGNATURE OF REGISTRAR		70. SIGNATURE OF PHYSICIAN	
71. SIGNATURE OF DECEASED		72. SIGNATURE OF NEXT OF KIN		73. SIGNATURE OF WITNESS		74. SIGNATURE OF REGISTRAR		75. SIGNATURE OF PHYSICIAN	
76. SIGNATURE OF DECEASED		77. SIGNATURE OF NEXT OF KIN		78. SIGNATURE OF WITNESS		79. SIGNATURE OF REGISTRAR		80. SIGNATURE OF PHYSICIAN	
81. SIGNATURE OF DECEASED		82. SIGNATURE OF NEXT OF KIN		83. SIGNATURE OF WITNESS		84. SIGNATURE OF REGISTRAR		85. SIGNATURE OF PHYSICIAN	
86. SIGNATURE OF DECEASED		87. SIGNATURE OF NEXT OF KIN		88. SIGNATURE OF WITNESS		89. SIGNATURE OF REGISTRAR		90. SIGNATURE OF PHYSICIAN	
91. SIGNATURE OF DECEASED		92. SIGNATURE OF NEXT OF KIN		93. SIGNATURE OF WITNESS		94. SIGNATURE OF REGISTRAR		95. SIGNATURE OF PHYSICIAN	
96. SIGNATURE OF DECEASED		97. SIGNATURE OF NEXT OF KIN		98. SIGNATURE OF WITNESS		99. SIGNATURE OF REGISTRAR		100. SIGNATURE OF PHYSICIAN	

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DEPARTMENT OF HEALTH - BALTIMORE 18

## CERTIFICATE OF DEATH

02587

Reg. Dist. No.

2596

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>AA</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gambrills</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>AA General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Jauniata</b> Middle <b>Mamie</b> Last <b>Anderson</b>		4. DATE OF DEATH Month <b>March</b> Day <b>1</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 8, 1939</b>
9. AGE (In years last birthday) <b>20</b> yrs.		IF UNDER 1 YEAR Months <b>20</b> Days <b>20</b> Hours <b>20</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Tennessee</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Wallace Roberts</b>		14. MOTHER'S MAIDEN NAME <b>Ellie Vaughn</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>none</b>	
17. INFORMANT <b>Charles Anderson, same as 2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>754.7</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>congenital Aneurysm</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>24 Hrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pregnancy 4 1/2 Mo 649x</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. <b>19</b> Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Feb 19</b> , 19 <b>59</b> , to <b>Mar 1</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Mar 1</b> , 19 <b>59</b> , and that death occurred at <b>6:05 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Edward G. Skerritt</b>		DATE SIGNED <b>3-3-59</b>	
PHYSICIAN'S NAME (Type) <b>Edward G. Skerritt, M.D.</b>		<b>Gambrills, Md.</b>	
22a. BURIAL, CREMATION, or other disposal (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3/4/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Memorial</b>	22d. LOCATION (City, town, or county) (State) <b>Glen Burnie, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping and Kirkley, Glen Burnie, Md.</b>		24a. REC'D BY REGISTRAR <b>MAR 4 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. H...</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2638

## CERTIFICATE OF DEATH

02588

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena RFD</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Long Point (Pasadena RFD)</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Long Point</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>S.</u> Last <u>Angel</u>				4. DATE OF DEATH Month <u>March</u> Day <u>4</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 3, 1907</u>	
9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chauffeur</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Self Emp</u>		11. BIRTHPLACE (State or foreign country) <u>W. Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>James Z. Angel</u>				14. MOTHER'S MAIDEN NAME <u>Mae (Unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Mrs. Rachael Angel Same As #7</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Carcinoma</u> 163X DUE TO <u>carcinoma of the lungs</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>2 months</u> (c) <u>2 months</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>January 3, 1959</u> , to <u>March 4, 1959</u> , that I last saw the deceased alive on <u>March 4, 1959</u> , and that death occurred at <u>2:10 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. M. McLaughlin</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>RFD 8 Box 442 Pasadena, Md. Mar. 4, 1959</u>			
PHYSICIAN'S NAME (Type) <u>R. M. McLaughlin</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 7, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>London Park</u>		22d. LOCATION (City, town, or county) (State) <u>Ba Ho., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. P. Sengh</u> ADDRESS <u>Spent Burnie, Md.</u>				24a. REC'D BY REGISTRAR <u>MAR 5 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Orthur L. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1933

Reg. Dist. No.

1. NAME OF DEATH		2. SEX		3. AGE		4. RACE		5. OCCUPATION		6. PLACE OF BIRTH		7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF REGISTRAR		13. SIGNATURE OF DEATH CERTIFICATE		14. SIGNATURE OF DEATH CERTIFICATE		15. SIGNATURE OF DEATH CERTIFICATE		16. SIGNATURE OF DEATH CERTIFICATE		17. SIGNATURE OF DEATH CERTIFICATE		18. SIGNATURE OF DEATH CERTIFICATE		19. SIGNATURE OF DEATH CERTIFICATE		20. SIGNATURE OF DEATH CERTIFICATE		21. SIGNATURE OF DEATH CERTIFICATE		22. SIGNATURE OF DEATH CERTIFICATE		23. SIGNATURE OF DEATH CERTIFICATE		24. SIGNATURE OF DEATH CERTIFICATE		25. SIGNATURE OF DEATH CERTIFICATE		26. SIGNATURE OF DEATH CERTIFICATE		27. SIGNATURE OF DEATH CERTIFICATE		28. SIGNATURE OF DEATH CERTIFICATE		29. SIGNATURE OF DEATH CERTIFICATE		30. SIGNATURE OF DEATH CERTIFICATE		31. SIGNATURE OF DEATH CERTIFICATE		32. SIGNATURE OF DEATH CERTIFICATE		33. SIGNATURE OF DEATH CERTIFICATE		34. SIGNATURE OF DEATH CERTIFICATE		35. SIGNATURE OF DEATH CERTIFICATE		36. SIGNATURE OF DEATH CERTIFICATE		37. SIGNATURE OF DEATH CERTIFICATE		38. SIGNATURE OF DEATH CERTIFICATE		39. SIGNATURE OF DEATH CERTIFICATE		40. SIGNATURE OF DEATH CERTIFICATE		41. SIGNATURE OF DEATH CERTIFICATE		42. SIGNATURE OF DEATH CERTIFICATE		43. SIGNATURE OF DEATH CERTIFICATE		44. SIGNATURE OF DEATH CERTIFICATE		45. SIGNATURE OF DEATH CERTIFICATE		46. SIGNATURE OF DEATH CERTIFICATE		47. SIGNATURE OF DEATH CERTIFICATE		48. SIGNATURE OF DEATH CERTIFICATE		49. SIGNATURE OF DEATH CERTIFICATE		50. SIGNATURE OF DEATH CERTIFICATE		51. SIGNATURE OF DEATH CERTIFICATE		52. SIGNATURE OF DEATH CERTIFICATE		53. SIGNATURE OF DEATH CERTIFICATE		54. SIGNATURE OF DEATH CERTIFICATE		55. SIGNATURE OF DEATH CERTIFICATE		56. SIGNATURE OF DEATH CERTIFICATE		57. SIGNATURE OF DEATH CERTIFICATE		58. SIGNATURE OF DEATH CERTIFICATE		59. SIGNATURE OF DEATH CERTIFICATE		60. SIGNATURE OF DEATH CERTIFICATE		61. SIGNATURE OF DEATH CERTIFICATE		62. SIGNATURE OF DEATH CERTIFICATE		63. SIGNATURE OF DEATH CERTIFICATE		64. SIGNATURE OF DEATH CERTIFICATE		65. SIGNATURE OF DEATH CERTIFICATE		66. SIGNATURE OF DEATH CERTIFICATE		67. SIGNATURE OF DEATH CERTIFICATE		68. SIGNATURE OF DEATH CERTIFICATE		69. SIGNATURE OF DEATH CERTIFICATE		70. SIGNATURE OF DEATH CERTIFICATE		71. SIGNATURE OF DEATH CERTIFICATE		72. SIGNATURE OF DEATH CERTIFICATE		73. SIGNATURE OF DEATH CERTIFICATE		74. SIGNATURE OF DEATH CERTIFICATE		75. SIGNATURE OF DEATH CERTIFICATE		76. SIGNATURE OF DEATH CERTIFICATE		77. SIGNATURE OF DEATH CERTIFICATE		78. SIGNATURE OF DEATH CERTIFICATE		79. SIGNATURE OF DEATH CERTIFICATE		80. SIGNATURE OF DEATH CERTIFICATE		81. SIGNATURE OF DEATH CERTIFICATE		82. SIGNATURE OF DEATH CERTIFICATE		83. SIGNATURE OF DEATH CERTIFICATE		84. SIGNATURE OF DEATH CERTIFICATE		85. SIGNATURE OF DEATH CERTIFICATE		86. SIGNATURE OF DEATH CERTIFICATE		87. SIGNATURE OF DEATH CERTIFICATE		88. SIGNATURE OF DEATH CERTIFICATE		89. SIGNATURE OF DEATH CERTIFICATE		90. SIGNATURE OF DEATH CERTIFICATE		91. SIGNATURE OF DEATH CERTIFICATE		92. SIGNATURE OF DEATH CERTIFICATE		93. SIGNATURE OF DEATH CERTIFICATE		94. SIGNATURE OF DEATH CERTIFICATE		95. SIGNATURE OF DEATH CERTIFICATE		96. SIGNATURE OF DEATH CERTIFICATE		97. SIGNATURE OF DEATH CERTIFICATE		98. SIGNATURE OF DEATH CERTIFICATE		99. SIGNATURE OF DEATH CERTIFICATE		100. SIGNATURE OF DEATH CERTIFICATE	
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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02589

Item 9, Film G241, 4/10/59 icy

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>2639</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> c. LENGTH OF STAY IN 1b <b>X Annapolis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>C. C.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Annapolis</b>	
3. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. 4 Bay 28A. Annapolis</b>		d. STREET ADDRESS <b>St. 4 Bay 28A</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Estella Baldwin</b>		4. DATE OF DEATH Month <b>3</b> Day <b>30</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Col.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-26-1893</b>
9. AGE (In years last birthday) <b>66</b> yrs.		IF UNDER 1 YEAR Months <b>6</b> Days <b>6</b>	IF UNDER 24 HRS. Hours <b>6</b> Min. <b>6</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hutchinson family</b>	
11. BIRTHPLACE (State or foreign country) <b>A.A. Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Job Stansbury</b>		14. MOTHER'S MAIDEN NAME <b>Delia Stansbury</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-32-0888</b>	
17. INFORMANT <b>Stacy Addison</b>		Address <b>St. 4 Bay 28A. Annapolis</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> <b>434.4</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Due to</b> (c) <b>Due to</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Interval between onset and death</b> <b>1 week</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>E. L. Whitford</b>		DATE SIGNED <b>3/30/59</b>	
EXAMINER'S NAME (Type) <b>E. L. Whitford</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4-3-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Broadneck</b>	22d. LOCATION (City, town, or county) (State) <b>St. Margarets, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Giese, D-Annapolis, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE MAR 31 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hester</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02590

2640

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b> <b>Dorchester</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Jessup, Md.</b>	c. LENGTH OF STAY IN 1b <b>18 mos.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b> <b>09-13-2</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Md. House of Correction Hospital</b>		d. STREET ADDRESS  e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>M James</b>		4. DATE OF DEATH Month <b>March</b> Day <b>7</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-6-10</b>
9. AGE (In years last birthday) <b>48</b> yrs.		10. IF UNDER 1 YEAR Months <b>48</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Grocer</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>11. BIRTHPLACE (State or foreign country)</b> <b>USA</b>	
13. FATHER'S NAME <b>William Bell</b>		14. MOTHER'S MAIDEN NAME <b>Belle Carry</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gangrene of Small Bowel</b> <b>577X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Adhesive Band</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>patial</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>partial</b>	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles S. Petty</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Charles S. Petty</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-13-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Silent City</b>		22d. LOCATION (City, town, or county) (State) <b>Cambridge, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>LEON HENRY, 222 Cedar St., Cambridge, Md.</b>		24. REC'D BY REGISTRAR DATE <b>APR 1 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2641 **CERTIFICATE OF DEATH**

02591

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Anne Arundel</u>		STATE <u>MARYLAND</u>		COUNTY <u>Anne Arundel</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>LAKE SHORE</u>		LENGTH OF STAY (in this place) <u>4 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>LAKE SHORE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5 LUKE DRIVE</u>				STREET ADDRESS (If rural give location) <u>5 LUKE DRIVE</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>KEITH</u> (First) <u>EUGENE</u> (Middle) <u>BENNETT</u> (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>MARCH 2,</u> <u>19 59</u>			
<b>5. SEX</b> <u>MALE</u>	<b>6. COLOR OR RACE</b> <u>WHITE</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>MARRIED</u>	<b>8. DATE OF BIRTH</b> <u>JULY 25, 1919</u>	<b>9. AGE last birthday</b> <u>39</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>PROJECTIONIST</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>MOTION PICTURES</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>MARYLAND</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>MAX BENNETT</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>MARY THOMPSON</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service) <u>YES WORLD WAR II</u>		<b>16. SOCIAL SECURITY NO.</b> <u>?</u>		<b>17. INFORMANT'S ADDRESS</b> <u>JEAN BENNETT 5 LUKE DRIVE</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>178X IMMEDIATE CAUSE (A)</b> <u>CIRCULATORY FAILURE</u>						<u>12 HOURS</u>	
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <u>WEIGHT LOSS, WIDESPREAD METASTASES</u>						<u>1 year</u>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)</b> <u>CARCINOMA OF TESTIS</u>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>on 3-2,</u> 19<u>59</u>, to <u>3-2,</u> 19<u>59</u>, that I last saw the deceased alive on <u>3-2,</u> 19<u>59</u>, and that death occurred at <u>6:10 P.</u> M, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>Dr. Vogel MD</u>		<b>ADDRESS</b> (Street, city, town, state) <u>403 RITCHIE H. GLEN BURNIE MD</u>		<b>DATE SIGNED</b> <u>3-3-59</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>BURIAL</u>		<b>DATE THEREOF</b> <u>3/5/59</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>BALTIMORE NATIONAL</u>		<b>LOCATION (City, town, or county)</b> <u>BALTIMORE MD</u>	
<b>24. REC'D BY REGISTRAR</b> DATE <u>MAR 6 '59</u>		<b>REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kline</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Geo. E. Schwab</u> ADDRESS <u>Funeral Home 2101 Frederick Ave</u>			





FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02592

Reg. Dist. No.

2642

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>A. R.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Severna Park</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Severna Park</b>		d. STREET ADDRESS <b>1</b>	
3. NAME OF DECEASED (Type or print) First <b>VELETA</b> Middle <b>T.</b> Last <b>BEST</b>		4. DATE OF DEATH Month <b>March</b> Day <b>18</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-16-1958</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Balto. Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Albert E. Best</b>		14. MOTHER'S MAIDEN NAME <b>Lillie M. Jackson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Lillie M. Jackson</b>		Address <b>Severna Park</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia due to otitis media, bilateral</b> 391.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an <u>Autopsy</u> <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Russell S. Fisher</b>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>March 18, 1959</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3-20-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Carpenter Hill</b>	22d. LOCATION (City, town, or county) (State) <b>Round Bay Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm Keese</b>		24a. REC'D BY REGISTRAR <b>MAR 23 '59</b>	
ADDRESS <b>#108 Wash. St. Annapolis Md.</b>		24b. REGISTRAR'S SIGNATURE <b>William S. Fisher</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



2597

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A. A.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <u>Md.</u> c. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Md.</u>		c. LENGTH OF STAY IN 1b <u>24 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel Gen Hosp</u>		d. STREET ADDRESS <u>Arnold</u>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Bissitt</u> Last <u>Bissitt</u>		4. DATE OF DEATH Month <u>3</u> Day <u>2</u> Year <u>1959</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 31, 1913</u>
9. AGE (In years last birthday) <u>45</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dairy</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>259-01-0263</u>	
17. INFORMANT <u>Self</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO <u>Coronary failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>Generalized arteriosclerosis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1957</u> , 19 <u>57</u> , to <u>1959</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3-1-59</u> , 19 <u>59</u> , and that death occurred at <u>330</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Severna Park Md</u> DATE SIGNED <u>3-2-59</u>			
ACTUAL SIGNATURE <u>Robert R. Holm</u> M.D.		PHYSICIAN'S NAME (Type) <u>Robert R. Holm</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 10-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ashby Hills Church Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arnold Anne Arundel Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Donald G. Fink</u>		ADDRESS <u>Severna Park Md</u>	
24a. REC'D BY REGISTRAR <u>MAR 11 1959</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Smith</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2643

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>S.</u> Last <u>Bradley</u>		4. DATE OF DEATH Month <u>March</u> Day <u>18</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 10, 1874</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Lumber Mill</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-34-4288</u>	
17. INFORMANT Address <u>Clifton Bradley, Tick Neck Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-vascular accident</u> DUE TO <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>same year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic CVD &amp; cardiac decompensation</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 1, 1956</u> to <u>March 18, 1959</u> , that I last saw the deceased alive on <u>March 12, 1959</u> , and that death occurred at <u>11:45 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. M. McLaughlin</u>		ADDRESS (Street, city or town, state) <u>RFD 8 Box 442 Pasadena, Md.</u>	
DATE SIGNED <u>March 18, 1959</u>			
PHYSICIAN'S NAME (Type) <u>R. M. McLaughlin</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/21/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>	22d. LOCATION (City, town, or county) (State) <u>Eastern Ave. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Justin E. Donovan</u>		ADDRESS <u>3818 Roland Ave</u>	
24a. REC'D BY REGISTRAR <u>MAR 23 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

STATE OF MARYLAND

1914

1914

NAME OF DECEASED		DATE OF DEATH	
JAMES H. HARRIS		JANUARY 1, 1914	
AGE		SEX	
65		Male	
RACE		COLOR	
White		White	
BIRTH		PLACE OF BIRTH	
JANUARY 1, 1849		BALTIMORE, MARYLAND	
OCCUPATION		CAUSE OF DEATH	
Retired		Heart Disease	
MANNER OF DEATH		EDUCATION	
Natural		High School	
RELIGION		MARITAL STATUS	
Roman Catholic		Married	
NAME OF WIFE		NAME OF CHILDREN	
Mary H. Harris		John H. Harris	
NAME OF NEXT OF KIN		NAME OF PHYSICIAN	
James H. Harris		Dr. J. H. Harris	
NAME OF BURIAL PLACE		NAME OF MINISTER	
St. James Church		Rev. J. H. Harris	
NAME OF FUNERAL HOME		NAME OF UNDERTAKER	
J. H. Harris		J. H. Harris	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 18 Film 240 4-6-59 ams MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 02598 Items 6, 7, 11, 12, 13, 14 Film 6239 3-9-59 et 2598 CERTIFICATE OF DEATH Reg. Dist. No.									
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			c. LENGTH OF STAY IN 1b <u>1 day</u>		X c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Annapolis, Md.</u>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>					d. STREET ADDRESS <u>1</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>BROOKS</u> Last <u>BROOKS</u>					4. DATE OF DEATH Month <u>March</u> Day <u>1</u> Year <u>1959.</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> ? DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-2-05</u>		9. AGE (In years last birthday) <u>54</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Caretaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Beach</u>		11. BIRTHPLACE (State or foreign country) <u>?</u>			12. CITIZEN OF WHAT COUNTRY? <u>?</u>		
13. FATHER'S NAME <u>?</u>				14. MOTHER'S MAIDEN NAME <u>?</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>				16. SOCIAL SECURITY NO. <u>INFORMANT</u>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonitis</u> <u>492X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>March 1, 1959</u> to <u>March 1, 1959</u> , that I last saw the deceased alive on <u>March 1, 1959</u> , and that death occurred at <u>2:25A</u> M, from the causes on and on the date stated above. ADDRESS (Street, city or town, state) <u>62 Cathedral St., Annapolis, Md.</u> DATE SIGNED <u>3/3/59</u> ACTUAL SIGNATURE <u>Aris T. Allen</u> M.D. PHYSICIAN'S NAME (Type) <u>Aris T. Allen</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>3-3-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Annapolis 21 of Md.</u>			22d. LOCATION (City, town, or county) (State) <u>Balta md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr.</u>					24a. REC'D BY REGISTRAR DATE <u>MAR 5 '59</u>		24b. REGISTRAR'S SIGNATURE <u>William E. Hume</u>		

02208

STATE OF DEATH

02208

State of New York

County of New York

City of New York

City of New York

State of New York

County of New York

County of New York

City of New York

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## CERTIFICATE OF DEATH

Reg. Dist. No.

2599

1. PLACE OF DEATH a. COUNTY <u>A.A.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>				c. LENGTH OF STAY IN 1b <u>1 DAY</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ANN ARUNDEL GEN. Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>BENJAMIN BROWN</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>20</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 9-1888</u>	9. AGE (In years last birthday) <u>70</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DAIRY CO. Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>ANNE ARUNDEL CO. Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>DANIEL BROWN</u>				14. MOTHER'S MAIDEN NAME <u>MARION LITTLE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>UNKNOWN</u>				16. SOCIAL SECURITY NO. <u>218-12-9B8-A</u>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic hypertension</u> DUE TO (c) <u>Vascular disease</u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
18. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 20, 1959</u> to <u>April 20, 1959</u> that I last saw the deceased alive on <u>March 20, 1959</u> and that death occurred at <u>1:00 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. E. Richardson</u>				ADDRESS (Street, city or town, state) <u>110-CLAY ST ANNAPOLIS, Md.</u> DATE SIGNED <u>3/23/59</u>			
PHYSICIAN'S NAME (Type) <u>Charles F. Hicks III</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-24-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Brewer-Hill</u>		22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS - Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles F. Hicks III</u>				24a. REC'D BY REGISTRAR <u>MAR 26 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrant prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02597

2644

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ventor Md.</u>		c. LENGTH OF STAY IN 1b <u>6 Mths.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Ventor Road</u>		d. STREET ADDRESS <u>Ventor Road</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLES HAMILTON BROWN</u>		4. DATE OF DEATH Month Day Year <u>MARCH 31 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-23-1883</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Caretaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Woodensburg, Balto, Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel H. Brown</u>		14. MOTHER'S MAIDEN NAME <u>Mart Melching</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>217-030 3545</u>	
17. INFORMANT <u>Alice May Brown</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u> DUE TO (c) <u>5 YEARS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 HOURS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>DEC. 18, 1958</u> to <u>MARCH 31, 1959</u> , that I last saw the deceased alive on <u>MARCH 30, 1959</u> , and that death occurred at <u>6:00 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. Brady Smith</u> M.D.		ADDRESS (Street, city or town, state) <u>Paradise Beach</u>	
PHYSICIAN'S NAME (Type) <u>J. BRADY SMITH</u>		DATE SIGNED <u>3/31/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-2-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge</u>		22d. LOCATION (City, town, or county) (State) <u>Washington Rd. Dorsey Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Murrel</u>		ADDRESS <u>Gileville S. Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>APR 3 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 10

00503

REG. NO.

PLACE OF BIRTH

MARYLAND

DATE OF BIRTH

DATE OF DEATH

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2645

**CERTIFICATE OF DEATH**

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundel</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>N. J.</u> <span style="float: right;">b. COUNTY <u>Bergen</u></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewater</u>				c. LENGTH OF STAY IN, lb <u>5 months</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Daughter's home</u>				e. STREET ADDRESS <u>44 Lake Rd.</u>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>William</u> <span style="float: right;">First Middle Last</span> <u>Butscher</u>				<b>4. DATE OF DEATH</b> Month <u>3</u> Day <u>20</u> Year <u>1959</u>			
5. SEX <u>M.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 6, 1872</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 MRS.		IF UNDER 24 MRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>New York City</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Otto Butscher</u>				14. MOTHER'S MAIDEN NAME <u>Louise Gumpert</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Sherwood H. Butscher (son)</u>				Address			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> <u>443x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive cardiovascular disease</u> DUE TO (c) <u>and carcinoma of prostate</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>3 months</u> <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>Jan 3</u> , 19 <u>59</u> , to <u>March</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>March 20</u> , 19 <u>59</u> , and that death occurred at <u>6:40 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Sylvia M. Lim</u> M.D. <u>RFD #1 Box 277-M</u> <u>3-20-59</u> PHYSICIAN'S NAME (Type) <u>Sylvia M. Lim, M.D.</u> <u>Edgewater, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>3-23-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>77 Lincoln Cent</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Julius M. Scyler Sons</u>				ADDRESS <u>Crimmopolis Md</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 24 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>				24c. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1

INSTRUCTIONS

TO ATTEND PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 TOM

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02600

# CERTIFICATE OF DEATH

2646 Item 5. see birth Cert. et

Reg. Dist. No. 27

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Fort George G. Meade</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Ft George G. Meade</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U.S. Army Hospital</u>				STREET ADDRESS (If rural give location) <u>Bldg 2365 Apt A</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>Frank Gerard Carr, Twin II</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>March 7 1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cau</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>5 March 1959</u>		9. AGE last birthday yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Perry Carr</u>				14. MOTHER'S MAIDEN NAME <u>Marie Tieyah</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT & ADDRESS <u>Hospital Records U.S. Army Hosp, Ft Meade, Md</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
776x IMMEDIATE CAUSE (A) <u>Prematurity</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5 March 1959</u> , to <u>7 March 1959</u> , that I last saw the deceased alive on <u>7 March 1959</u> , and that death occurred at <u>1145A</u> AM, from the causes and on the date stated above.							
SIGNATURE <u>Roger C. Mager</u> M.D.				ADDRESS (Street, city, town, state) <u>U.S. Army Hosp, Ft Meade, Md</u>			
DATE SIGNED <u>7 Mar 59</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		DATE THEREOF <u>9 March 59</u>		NAME OF CEMETERY OR CREMATORY <u>Laboratory U.S. Army Hospital</u>		LOCATION (City, town, or county) (State) <u>Ft G. Meade, Md</u>	
24. REC'D BY REGISTRAR DATE <u>MAR 12 '59</u>		REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur M. Ellis</u>		ADDRESS <u>U.S. Army Hosp, Ft Meade, Md</u>	

25250368XV23

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, date of death, place of death, cause of death, and physician's signature.

INSTRUCTIONS  
10. Write name of deceased in full, including middle name or initial, and date of birth.  
11. Write date of death in full.  
12. Write place of death in full.  
13. Write cause of death in full, using standard medical terminology.  
14. Write name of physician in full, including title.  
15. Write name of informant in full, including title.  
16. Write name of registrar in full, including title.  
17. Write name of funeral home in full, including address.  
18. Write name of cemetery in full, including address.  
19. Write name of religious organization in full, including address.  
20. Write name of next of kin in full, including address.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
 15M 9/55

Item 5, see birth Cert. et  
**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**2647**  
**CERTIFICATE OF DEATH**

02601

Reg. Dist. No. 27

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort George G. Meade, Md</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. S. Army Hospital</u>				/ d. STREET ADDRESS <u>Bldg 2365 Apt A</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Norma</u> Middle <u>Jean</u> <u>Twin I Carr</u>				4. DATE OF DEATH Month <u>March</u> Day <u>6</u> Year <u>19 59</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cau</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5 March 1959</u>		9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR Months <u>27</u> Days <u>27</u>	IF UNDER 24 HRS. Hours <u>27</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>John Perry Carr</u>				14. MOTHER'S MAIDEN NAME <u>Marie Tieyah</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Father Bldg 2365 Apt A, Ft George G. Meade, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lung disease-possible hyaline membrane disease</u> <u>773.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Prematurity</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>27 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5 March</u> , 19 <u>59</u> , to <u>6 March</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>6 March</u> , 19 <u>59</u> , and that death occurred at <u>8:10 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>FRED W. LAFFERTY, Capt., MC</u> <u>MD. US ARMY HOSP, FT GEO G MEADE, MD</u> <u>6 Mar 59</u>							
ACTUAL SIGNATURE <u>Fred W. Lafferty</u>							
PHYSICIAN'S NAME (Type) <u>FRED W. LAFFERTY, Capt., MC</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>6 March 59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>U.S. Army Hosp (Laboratory)</u>		22d. LOCATION (City, town, or county) (State) <u>Ft George G. Meade, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur L. Frank</u>				ADDRESS <u>USAH Fort Geo. G. Meade</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 12 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>							

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bM



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrars prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02602

2648

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>A.A.CO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MILLERSVILLE</u>		c. LENGTH OF STAY IN 1b <u>1 month</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SANN'S NURSING HOME</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ELLA</u> Middle <u>M.</u> Last <u>CASTLES</u>		4. DATE OF DEATH Month <u>3</u> Day <u>10</u> Year <u>1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-20-1875</u>
9. AGE (In years lost birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Isaac Bishop</u>		14. MOTHER'S MAIDEN NAME <u>Wingate, Amanda</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT Address <u>Mary Newberger, Millersville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 490X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Latent Pneumonia</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Thrombosis - 6 months</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>1 week</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-27-59</u> to <u>March 10-59</u> , that I last saw the deceased alive on <u>3-9-59</u> , 19 <u>59</u> , and that death occurred <u>2:00</u> M, from the causes and on the date stated above.		ADDRESS (street, city or town, state) <u>Chesapeake, Md.</u> DATE SIGNED <u>March 12 '59</u>	
ACTUAL SIGNATURE <u>DR. JOSEPH LIPSKY</u>		PHYSICIAN'S NAME (Type) <u>OMENTON, MARYLAND</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-13-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>West Laurel Hill Cent.</u>		22d. LOCATION (City, town, or county) (State) <u>Phila. Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sr.</u>		24a. REC'D BY REGISTRAR <u>MAR 12 '59</u>	
ADDRESS <u>Annapolis Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

02802

CERTIFICATE OF DEATH

1944

THE REV. DR. J. J. LISKY

MD

A. A. CO.

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DR. JOSEPH LISKY  
Ottawa, Ontario

2649  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>AN. Md</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DILL Rd.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Severna Park</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>George John Clark</u>		4. DATE OF DEATH <u>3-3-59</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-31-1885</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR: Months <u>7</u> Days <u>3</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Soap</u>	
11. BIRTHPLACE (State or foreign country) <u>Roxanna Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u> Cyrus Clark</u>		14. MOTHER'S MAIDEN NAME <u>Melvin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>                    </u>	
17. INFORMANT <u>                    </u>		Address <u>                    </u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute Myocardial Infarction</u> DUE TO (c) <u>Gen. arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>                    </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1955</u> , 19 <u>                    </u> , to <u>                    </u> , 19 <u>                    </u> , that I last saw the deceased alive on <u>Feb 25</u> , 19 <u>                    </u> , and that death occurred at <u>10:30</u> AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert B. Hahn</u> M.D.		ADDRESS (Street, city or town, state) <u>Severna Park Md</u> DATE SIGNED <u>3-3-59</u>	
PHYSICIAN'S NAME (Type) <u>Robert B. HAHN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/6/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Anne Arundel Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>                    </u> ADDRESS <u>Glen Burnie Md</u>		24a. REC'D BY REGISTRAR <u>                    </u> 24b. REGISTRAR'S SIGNATURE <u>                    </u>	
DATE <u>MAR 5 '59</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

10-10-68

1. NAME OF DECEASED <u>JOHN J. SMITH</u>		2. SEX <u>MALE</u>		3. AGE <u>45</u>	
4. DATE OF DEATH <u>10-10-68</u>		5. TIME OF DEATH <u>10:30 AM</u>		6. PLACE OF DEATH <u>HOME</u>	
7. CAUSE OF DEATH <u>HEART DISEASE</u>		8. MANNER OF DEATH <u>NATURAL</u>		9. SIGNATURE OF PHYSICIAN <u>[Signature]</u>	
10. SIGNATURE OF REGISTRAR <u>[Signature]</u>		11. SIGNATURE OF WITNESS <u>[Signature]</u>		12. SIGNATURE OF DECEASED <u>[Signature]</u>	
13. SIGNATURE OF DECEASED <u>[Signature]</u>		14. SIGNATURE OF DECEASED <u>[Signature]</u>		15. SIGNATURE OF DECEASED <u>[Signature]</u>	
16. SIGNATURE OF DECEASED <u>[Signature]</u>		17. SIGNATURE OF DECEASED <u>[Signature]</u>		18. SIGNATURE OF DECEASED <u>[Signature]</u>	
19. SIGNATURE OF DECEASED <u>[Signature]</u>		20. SIGNATURE OF DECEASED <u>[Signature]</u>		21. SIGNATURE OF DECEASED <u>[Signature]</u>	
22. SIGNATURE OF DECEASED <u>[Signature]</u>		23. SIGNATURE OF DECEASED <u>[Signature]</u>		24. SIGNATURE OF DECEASED <u>[Signature]</u>	
25. SIGNATURE OF DECEASED <u>[Signature]</u>		26. SIGNATURE OF DECEASED <u>[Signature]</u>		27. SIGNATURE OF DECEASED <u>[Signature]</u>	
28. SIGNATURE OF DECEASED <u>[Signature]</u>		29. SIGNATURE OF DECEASED <u>[Signature]</u>		30. SIGNATURE OF DECEASED <u>[Signature]</u>	
31. SIGNATURE OF DECEASED <u>[Signature]</u>		32. SIGNATURE OF DECEASED <u>[Signature]</u>		33. SIGNATURE OF DECEASED <u>[Signature]</u>	
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52. SIGNATURE OF DECEASED <u>[Signature]</u>		53. SIGNATURE OF DECEASED <u>[Signature]</u>		54. SIGNATURE OF DECEASED <u>[Signature]</u>	
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61. SIGNATURE OF DECEASED <u>[Signature]</u>		62. SIGNATURE OF DECEASED <u>[Signature]</u>		63. SIGNATURE OF DECEASED <u>[Signature]</u>	
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79. SIGNATURE OF DECEASED <u>[Signature]</u>		80. SIGNATURE OF DECEASED <u>[Signature]</u>		81. SIGNATURE OF DECEASED <u>[Signature]</u>	
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88. SIGNATURE OF DECEASED <u>[Signature]</u>		89. SIGNATURE OF DECEASED <u>[Signature]</u>		90. SIGNATURE OF DECEASED <u>[Signature]</u>	
91. SIGNATURE OF DECEASED <u>[Signature]</u>		92. SIGNATURE OF DECEASED <u>[Signature]</u>		93. SIGNATURE OF DECEASED <u>[Signature]</u>	
94. SIGNATURE OF DECEASED <u>[Signature]</u>		95. SIGNATURE OF DECEASED <u>[Signature]</u>		96. SIGNATURE OF DECEASED <u>[Signature]</u>	
97. SIGNATURE OF DECEASED <u>[Signature]</u>		98. SIGNATURE OF DECEASED <u>[Signature]</u>		99. SIGNATURE OF DECEASED <u>[Signature]</u>	
100. SIGNATURE OF DECEASED <u>[Signature]</u>		101. SIGNATURE OF DECEASED <u>[Signature]</u>		102. SIGNATURE OF DECEASED <u>[Signature]</u>	

2650

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.A.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>AA.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>50 Brooklyn.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>206 Alameda Rd</u>		e. STREET ADDRESS <u>206 Alameda Rd</u>	
3. NAME OF DECEASED (Type or print) <u>CELENE L. Clayton Jr</u> First Middle Last		4. DATE OF DEATH <u>3-1-59</u> Month Day Year	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/8/98</u>
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fire fighter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B.C.F.</u>	
11. BIRTHPLACE (State or foreign country) <u>Ind.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>James.</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Spruiell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Family - Same</u>	
17. INFORMANT <u>Family - Same</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> DUE TO <u>422.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>A.S.C.V.D. &amp; Pulm Emphysema &amp; Fibrosis</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>28 Feb 59</u> <u>1 Mar 59</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Apr</u> 19 <u>57</u> , to <u>March</u> 19 <u>59</u> , that I last saw the deceased alive on <u>28 Feb 59</u> , 19 <u>59</u> , and that death occurred at <u>1:15 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Andrew R. Sushowski</u>		ADDRESS (Street, city or town, state) <u>4016 Ritchie Hwy Balt Md 21205</u>	
PHYSICIAN'S NAME (Type) <u>Andrew R. Sushowski M.D.</u>		DATE SIGNED <u>MD 59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>3/4/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	22d. LOCATION (City, town, or county) (State) <u>BALTO.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>DeLaney Funeral Home</u>		ADDRESS <u>130 E. Fort Ave.</u>	
24a. REC'D BY REGISTRAR <u>MAR 4 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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2651

Item 1 Film G239 3-16-59 et

## CERTIFICATE OF DEATH

02605

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>AA</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>AA</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lothian</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>90 Moreland Nursing Home</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Clarence Lee Cowles</i>		4. DATE OF DEATH Month Day Year <i>Mar 6 1959</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-4-1872</i>
9. AGE (In years last birthday) <i>86</i>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Supt of Schools</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Supt of Schools</i>	
11. BIRTHPLACE (State or foreign country) <i>Vermont</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>Albert Lee Cowles</i>		14. MOTHER'S MAIDEN NAME <i>Mary Whitney</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>William G. Husted</i>		Address <i>(2)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>coronary occlusion</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>generalized arteriosclerosis</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>fractured hip (old)</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Sept - 1957</i> to <i>March 6 1959</i> , that I last saw the deceased alive on <i>Nov. 1958</i> , and that death occurred at <i>2 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Emily H. Wilson</i> M.D.		ADDRESS (Street, city or town, state) <i>Lathem Md</i> DATE SIGNED <i>3-6-59</i>	
PHYSICIAN'S NAME (Type) <i>EMILY H WILSON</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	22b. DATE THEREOF <i>3-7-59</i>	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State) <i>Trasburg VT</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Saylor</i>		24a. REC'D BY REGISTRAR DATE <i>MAR 11 '59</i>	
ADDRESS <i>Annapolis Md.</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2600

## CERTIFICATE OF DEATH

02606

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>823 Spa Road</u>		d. STREET ADDRESS <u>1 823 Spa Road</u>	
3. NAME OF DECEASED (Type or print) <u>Elizabeth</u> First <u>Creek</u> Middle Last		DATE OF DEATH <u>3</u> Month <u>14</u> Day <u>1959</u> Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-27-1872</u>
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>A.A. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Hawkins</u>		14. MOTHER'S MAIDEN NAME <u>Triscilla Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4341</u> DUE TO <u>Longestime Embolic Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-14-59</u> , 19 <u>59</u> , to <u>3-14-59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3-14-59</u> , 19 <u>59</u> , and that death occurred at <u>12:15</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A.T. Allen</u>		ADDRESS (Street, city or town, state) <u>62 Cathedral St Annapolis Md.</u> DATE SIGNED <u>3-14-59</u>	
PHYSICIAN'S NAME (Type) <u>A.T. ALLEN</u>		<u>Annapolis Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>3-18-59</u>	<u>Brewer Hill</u>	<u>Annapolis, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr. - Annapolis, Md.</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>MAR 18 '59</u>		24b. REGISTRAR'S SIGNATURE <u>William E. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

02607

2601

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. LENGTH OF STAY IN 1b <b>16 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle Last <b>Crowner</b>				4. DATE OF DEATH Month <b>March</b> Day <b>26</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) <b>77</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>United States</b>
13. FATHER'S NAME <b>Benjamin Crowner</b>				14. MOTHER'S MAIDEN NAME <b>Caroline Crowner</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT <b>Alexander Crowner</b>		Address <b>Galesville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Renal Insufficiency due to</b> <b>446 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>Arteriosclerotic Hypertension</b> DUE TO (c) <b>Vascular disease</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Galesville</b>	(County) <b>Anne Arundel</b>	(State) <b>Md.</b>		
21. I certify that I attended the deceased from <b>March 10, 1959</b> to <b>March 26, 1959</b> , that I last saw the deceased alive on <b>March 26, 1959</b> , and that death occurred at <b>12:40 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>R. L. Richardson</b>		ADDRESS (Street, city or town, state) <b>M.D. 110-CLAY ST ANNAPOLIS, MD 21403</b>					
PHYSICIAN'S NAME (Type) <b>R. L. Richardson</b>		DATE SIGNED <b>March 26, 1959</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-29-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Crowners Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Galesville Md</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Reese #108 Wash. St. Anna. Md</b>		ADDRESS		24a. REC'D BY REGISTRAR <b>DATE MAR 31 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>		

10030

CERTIFICATE OF DEATH

10030





2602

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>10</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>107 Clay St.</u>				d. STREET ADDRESS <u>107 Clay St.</u>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>E</u> Last <u>DAVIS</u>				4. DATE OF DEATH Month <u>3</u> Day <u>2</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Col.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-4-1894</u>	
9. AGE (In years lost birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>28</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Naval and Coast Port, Md.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>Vergil Davis</u>				14. MOTHER'S MAIDEN NAME <u>Mary Peel</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>yes now</u>				16. SOCIAL SECURITY NO. <u>Jessie Davis - Annapolis, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary artery disease</u> DUE TO (c) <u></u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 1, 1958</u> to <u>March 2, 1959</u> that I last saw the deceased alive on <u>March 2, 1959</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. L. Richman, M.D.</u>				ADDRESS (Street, city or town, state) <u>M.D. 110 - Clay Street Annapolis, Md.</u>			
DATE SIGNED <u>3/2/59</u>							
PHYSICIAN'S NAME (Type) <u>William Reese, M.D. - Annapolis, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-5-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Still</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, M.D. - Annapolis, Md.</u>				24a. REC'D BY REGISTRAR <u>3/3/59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kona</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

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page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Handwritten notes, mostly illegible due to bleed-through from the reverse side. Some legible fragments include:  
- "The following is a list of the names of the persons who have been named in the above mentioned cases."  
- "The names of the persons who have been named in the above mentioned cases are as follows:"  
- "The names of the persons who have been named in the above mentioned cases are as follows:"  
- "The names of the persons who have been named in the above mentioned cases are as follows:"

Handwritten notes at the bottom of the page, mostly illegible. Some legible fragments include:  
- "The names of the persons who have been named in the above mentioned cases are as follows:"  
- "The names of the persons who have been named in the above mentioned cases are as follows:"  
- "The names of the persons who have been named in the above mentioned cases are as follows:"

2603

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewater</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Anne Arundel General Hospital</u>				e. STREET ADDRESS <u>Box 337</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MICHAEL</u> <u>Dawson</u>				4. DATE OF DEATH Month Day Year <u>March</u> <u>4</u> <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 4, 1959</u>	9. AGE (In years lost birthday) yrs. <u>3</u>	IF UNDER 1 YEAR Months Days <u>3</u> <u>30</u>	IF UNDER 24 HRS. Hours Min. <u>3</u> <u>30</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Annapolis, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Donald Stewart Dawson</u>				14. MOTHER'S MAIDEN NAME <u>Dora Antoinette Koogle</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>---</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>---</u>		INFORMANT Address <u>Mother Box 337, Edgewater, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776x</u> DUE TO <u>Prematurity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <u>5 months</u> (c) <u>INTERVAL BETWEEN ONSET OF DEATH</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-4-59</u> , 19 <u>59</u> , to <u>3-4-59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3-4-59</u> , 19 <u>59</u> , and that death occurred at <u>11 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Albert L. Anderson</u> M.D. <u>44 Southgate Ave. Annapolis, Md.</u>							
ACTUAL SIGNATURE <u>Albert L. Anderson</u>		PHYSICIAN'S NAME (Type) <u>Albert L. Anderson MD</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 5, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mayo Memorial Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Mayo, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOPPING FUNERAL HOME</u>				ADDRESS <u>Annapolis, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 9 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Albert L. Anderson</u>							

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VS A15 (4)  
15M 9/58

2063373xv0

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STATE OF NEW YORK  
OFFICE OF THE ATTORNEY GENERAL  
INVESTIGATION OF DEATH

1. Name of Deceased: \_\_\_\_\_

2. Date of Death: \_\_\_\_\_

3. Place of Death: \_\_\_\_\_

4. Cause of Death: \_\_\_\_\_

5. Manner of Death: \_\_\_\_\_

6. Name of Physician: \_\_\_\_\_

7. Name of Coroner: \_\_\_\_\_

8. Name of Medical Examiner: \_\_\_\_\_

9. Name of Pathologist: \_\_\_\_\_

10. Name of Forensic Pathologist: \_\_\_\_\_

11. Name of Toxicologist: \_\_\_\_\_

12. Name of Chemist: \_\_\_\_\_

13. Name of Microscopist: \_\_\_\_\_

14. Name of Radiologist: \_\_\_\_\_

15. Name of Histopathologist: \_\_\_\_\_

16. Name of Immunologist: \_\_\_\_\_

17. Name of Geneticist: \_\_\_\_\_

18. Name of Epidemiologist: \_\_\_\_\_

19. Name of Biostatistician: \_\_\_\_\_

20. Name of Public Health Officer: \_\_\_\_\_

21. Name of Health Department: \_\_\_\_\_

22. Name of County Health Department: \_\_\_\_\_

23. Name of City Health Department: \_\_\_\_\_

24. Name of Town Health Department: \_\_\_\_\_

25. Name of Village Health Department: \_\_\_\_\_

26. Name of Ward Health Department: \_\_\_\_\_

27. Name of Precinct Health Department: \_\_\_\_\_

28. Name of Block Health Department: \_\_\_\_\_

29. Name of Lot Health Department: \_\_\_\_\_

30. Name of Street Health Department: \_\_\_\_\_

31. Name of Avenue Health Department: \_\_\_\_\_

32. Name of Highway Health Department: \_\_\_\_\_

33. Name of Waterway Health Department: \_\_\_\_\_

34. Name of Airway Health Department: \_\_\_\_\_

35. Name of Land Health Department: \_\_\_\_\_

36. Name of Water Health Department: \_\_\_\_\_

37. Name of Air Health Department: \_\_\_\_\_

38. Name of Land Health Department: \_\_\_\_\_

39. Name of Water Health Department: \_\_\_\_\_

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62. Name of Land Health Department: \_\_\_\_\_

63. Name of Water Health Department: \_\_\_\_\_

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72. Name of Water Health Department: \_\_\_\_\_

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86. Name of Land Health Department: \_\_\_\_\_

87. Name of Water Health Department: \_\_\_\_\_

88. Name of Air Health Department: \_\_\_\_\_

89. Name of Land Health Department: \_\_\_\_\_

90. Name of Water Health Department: \_\_\_\_\_

91. Name of Air Health Department: \_\_\_\_\_

92. Name of Land Health Department: \_\_\_\_\_

93. Name of Water Health Department: \_\_\_\_\_

94. Name of Air Health Department: \_\_\_\_\_

95. Name of Land Health Department: \_\_\_\_\_

96. Name of Water Health Department: \_\_\_\_\_

97. Name of Air Health Department: \_\_\_\_\_

98. Name of Land Health Department: \_\_\_\_\_

99. Name of Water Health Department: \_\_\_\_\_

100. Name of Air Health Department: \_\_\_\_\_

## CERTIFICATE OF DEATH

Reg. Dist. No.

2604

1. PLACE OF DEATH a. COUNTY <i>A.A.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>A.A.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>A.A. General Hospital</i>		d. STREET ADDRESS <i>11214 Grant St</i>	
3. NAME OF DECEASED (Type or print) First <i>Milton</i> Middle <i>Dawson</i> Last <i>Dawson</i>		4. DATE OF DEATH Month <i>3-</i> Day <i>30</i> Year <i>1959</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 19-1874</i>
9. AGE (In years last birthday) <i>84</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Waterman Crab Fish</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>	
11. BIRTHPLACE (State or foreign country) <i>Mayo Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>Joseph J. Dawson</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>Enola L Dawson</i>	
17. INFORMANT <i>Enola L Dawson</i>		Address <i>(2)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia, left lung</i> <i>493X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>March 28, 1959</i> to <i>March 30, 1959</i> , that I last saw the deceased alive on <i>March 30, 1959</i> , and that death occurred at <i>10:30</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>121 Cathedral Annapolis Md</i> DATE SIGNED <i>3/31/59</i>			
ACTUAL SIGNATURE <i>John E. Hedeman</i> M.D.		PHYSICIAN'S NAME (Type) <i>Annapolis Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>4-1-59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Mayo Memorial</i>	22d. LOCATION (City, town, or county) (State) <i>Mayo Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons</i>		24a. REC'D BY REGISTRAR DATE <i>APR 2 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Christina L. Kraus</i>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## CERTIFICATE OF DEATH

Reg. Dist. No. 02611

2605

1. PLACE OF DEATH a. COUNTY <i>aa</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>aa</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>A.A. General</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Susan</i> Middle <i>A.</i> Last <i>Deffenbaugh</i>		4. DATE OF DEATH Month <i>3</i> - Day <i>6</i> Year <i>1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept 5 1876</i>
9. AGE (In years last birthday) <i>82</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House Wife</i>	
11. BIRTHPLACE (State or foreign country) <i>Cambridge Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Dail</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mr Russell E. Hallock</i>		Address <i>(2)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebrovascular accident 3/4/59</i> 904.0 DUE TO (b) <i>Thrombosis? Hemorrhage? cerebral</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <i>Senile changes - fractured left hip</i>			INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>aged - senile changes - cardiovascular disease</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Fell in her home, fractured left hip</i>	
20c. TIME OF INJURY Month, Day, Year <i>3-24-1959</i> Hour <i>3:30</i> a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>	20f. (City or town) (County) (State) <i>Annapolis Anne Arundel Md</i>
21. I certify that I attended the deceased from <i>Feb 24, 1959</i> to <i>March 6, 1959</i> , that I last saw the deceased alive on <i>March 6, 1959</i> , and that death occurred at <i>4:25 P.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Harold R. Bohman</i> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <i>96 Cathedral St, Annapolis Md 3/9/59</i>	
PHYSICIAN'S NAME (Type) <i>Harold R. Bohman</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>3-9-59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Edwards Chapel</i>	22d. LOCATION (City, town, or county) (State) <i>Parole Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons</i>		ADDRESS <i>Annapolis Md</i>	
24a. REC'D BY REGISTRAR DATE <i>MAR 11 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur E. Kline</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02612

2606

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A.A. General Hospital</u>		d. STREET ADDRESS <u>Route 5, Box 61</u>	
3. NAME OF DECEASED (Type or print) First <u>Rena</u> Middle <u>L.</u> Last <u>Despeaux</u>		4. DATE OF DEATH Month <u>March</u> Day <u>29</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 6, 1891</u>
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Practical Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>State Hospital</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Walter Crawford</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-22-0476</u>	
17. INFORMANT <u>Charles Despeaux, Jr., Rt. 5, Box 61, Pasadena, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive vascular disease</u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 months</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Hour <u>  </u> o. m. <u>  </u> p. m. <u>  </u> Month <u>  </u> Day <u>  </u> Year <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 1955</u> , to <u>March 29, 1959</u> , that I last saw the deceased alive on <u>March 29, 1959</u> , and that death occurred at <u>1:35 p. m.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward S. Beck</u> M.D.		ADDRESS (Street, city or town, state) <u>41 Southgate Avenue</u> DATE SIGNED <u>3-29-59</u>	
PHYSICIAN'S NAME (Type) <u>Edward S. Beck</u>		<u>Annapolis, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-2-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1217 St. Paul Street</u>		24a. REC'D BY REGISTRAR DATE <u>APR 3 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

02613

CERTIFICATE OF DEATH

2008

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. DATE OF DEATH April 4, 1968		5. TIME OF DEATH 2:01 PM		6. PLACE OF DEATH MEMPHIS, TENNESSEE	
7. CAUSE OF DEATH SHOOTING		8. MANNER OF DEATH HOMICIDE		9. PLACE OF BIRTH MOBILE, ALABAMA	
10. OCCUPATION None		11. EDUCATION High School		12. MARITAL STATUS Single	
13. PREVIOUS ILLNESS None		14. PREVIOUS SURGERY None		15. PREVIOUS TRAUMA None	
16. PREVIOUS DRUGS None		17. PREVIOUS ALCOHOL None		18. PREVIOUS TOBACCO None	
19. PREVIOUS MEDICATION None		20. PREVIOUS VACCINATIONS None		21. PREVIOUS TRANSFUSIONS None	
22. PREVIOUS ORGANS None		23. PREVIOUS TISSUES None		24. PREVIOUS CELLS None	
25. PREVIOUS BLOOD None		26. PREVIOUS URINE None		27. PREVIOUS STOOL None	
28. PREVIOUS SWEAT None		29. PREVIOUS TEARS None		30. PREVIOUS SALIVA None	
31. PREVIOUS HAIR None		32. PREVIOUS NAILS None		33. PREVIOUS SKIN None	
34. PREVIOUS EYES None		35. PREVIOUS EARS None		36. PREVIOUS NOSE None	
37. PREVIOUS MOUTH None		38. PREVIOUS THROAT None		39. PREVIOUS LUNGS None	
40. PREVIOUS HEART None		41. PREVIOUS LIVER None		42. PREVIOUS SPLEEN None	
43. PREVIOUS PANCREAS None		44. PREVIOUS STOMACH None		45. PREVIOUS INTESTINES None	
46. PREVIOUS BLADDER None		47. PREVIOUS UTERUS None		48. PREVIOUS VAGINA None	
49. PREVIOUS PENIS None		50. PREVIOUS TESTES None		51. PREVIOUS PROSTATE None	
52. PREVIOUS THYROID None		53. PREVIOUS PARATHYROID None		54. PREVIOUS ADRENAL None	
55. PREVIOUS PITUITARY None		56. PREVIOUS HYPOTHYROID None		57. PREVIOUS DIAPHRAGM None	
58. PREVIOUS PERICARDIUM None		59. PREVIOUS ENDOMETRIUM None		60. PREVIOUS CERVIX None	
61. PREVIOUS VULVA None		62. PREVIOUS CLITORIS None		63. PREVIOUS GLANDS None	
64. PREVIOUS NERVES None		65. PREVIOUS MUSCLES None		66. PREVIOUS BONES None	
67. PREVIOUS JOINTS None		68. PREVIOUS SKELTON None		69. PREVIOUS DENTITION None	
70. PREVIOUS ORGANS None		71. PREVIOUS TISSUES None		72. PREVIOUS CELLS None	
73. PREVIOUS BLOOD None		74. PREVIOUS URINE None		75. PREVIOUS STOOL None	
76. PREVIOUS SWEAT None		77. PREVIOUS TEARS None		78. PREVIOUS SALIVA None	
79. PREVIOUS HAIR None		80. PREVIOUS NAILS None		81. PREVIOUS SKIN None	
82. PREVIOUS EYES None		83. PREVIOUS EARS None		84. PREVIOUS NOSE None	
85. PREVIOUS MOUTH None		86. PREVIOUS THROAT None		87. PREVIOUS LUNGS None	
88. PREVIOUS HEART None		89. PREVIOUS LIVER None		90. PREVIOUS SPLEEN None	
91. PREVIOUS PANCREAS None		92. PREVIOUS STOMACH None		93. PREVIOUS INTESTINES None	
94. PREVIOUS BLADDER None		95. PREVIOUS UTERUS None		96. PREVIOUS VAGINA None	
97. PREVIOUS PENIS None		98. PREVIOUS TESTES None		99. PREVIOUS PROSTATE None	
100. PREVIOUS THYROID None		101. PREVIOUS PARATHYROID None		102. PREVIOUS ADRENAL None	
103. PREVIOUS PITUITARY None		104. PREVIOUS HYPOTHYROID None		105. PREVIOUS DIAPHRAGM None	
106. PREVIOUS PERICARDIUM None		107. PREVIOUS ENDOMETRIUM None		108. PREVIOUS CERVIX None	
109. PREVIOUS VULVA None		110. PREVIOUS CLITORIS None		111. PREVIOUS GLANDS None	
112. PREVIOUS NERVES None		113. PREVIOUS MUSCLES None		114. PREVIOUS BONES None	
115. PREVIOUS JOINTS None		116. PREVIOUS SKELTON None		117. PREVIOUS DENTITION None	
118. PREVIOUS ORGANS None		119. PREVIOUS TISSUES None		120. PREVIOUS CELLS None	
121. PREVIOUS BLOOD None		122. PREVIOUS URINE None		123. PREVIOUS STOOL None	
124. PREVIOUS SWEAT None		125. PREVIOUS TEARS None		126. PREVIOUS SALIVA None	
127. PREVIOUS HAIR None		128. PREVIOUS NAILS None		129. PREVIOUS SKIN None	
130. PREVIOUS EYES None		131. PREVIOUS EARS None		132. PREVIOUS NOSE None	
133. PREVIOUS MOUTH None		134. PREVIOUS THROAT None		135. PREVIOUS LUNGS None	
136. PREVIOUS HEART None		137. PREVIOUS LIVER None		138. PREVIOUS SPLEEN None	
139. PREVIOUS PANCREAS None		140. PREVIOUS STOMACH None		141. PREVIOUS INTESTINES None	
142. PREVIOUS BLADDER None		143. PREVIOUS UTERUS None		144. PREVIOUS VAGINA None	
145. PREVIOUS PENIS None		146. PREVIOUS TESTES None		147. PREVIOUS PROSTATE None	
148. PREVIOUS THYROID None		149. PREVIOUS PARATHYROID None		150. PREVIOUS ADRENAL None	
151. PREVIOUS PITUITARY None		152. PREVIOUS HYPOTHYROID None		153. PREVIOUS DIAPHRAGM None	
154. PREVIOUS PERICARDIUM None		155. PREVIOUS ENDOMETRIUM None		156. PREVIOUS CERVIX None	
157. PREVIOUS VULVA None		158. PREVIOUS CLITORIS None		159. PREVIOUS GLANDS None	
160. PREVIOUS NERVES None		161. PREVIOUS MUSCLES None		162. PREVIOUS BONES None	
163. PREVIOUS JOINTS None		164. PREVIOUS SKELTON None		165. PREVIOUS DENTITION None	
166. PREVIOUS ORGANS None		167. PREVIOUS TISSUES None		168. PREVIOUS CELLS None	
169. PREVIOUS BLOOD None		170. PREVIOUS URINE None		171. PREVIOUS STOOL None	
172. PREVIOUS SWEAT None		173. PREVIOUS TEARS None		174. PREVIOUS SALIVA None	
175. PREVIOUS HAIR None		176. PREVIOUS NAILS None		177. PREVIOUS SKIN None	
178. PREVIOUS EYES None		179. PREVIOUS EARS None		180. PREVIOUS NOSE None	
181. PREVIOUS MOUTH None		182. PREVIOUS THROAT None		183. PREVIOUS LUNGS None	
184. PREVIOUS HEART None		185. PREVIOUS LIVER None		186. PREVIOUS SPLEEN None	
187. PREVIOUS PANCREAS None		188. PREVIOUS STOMACH None		189. PREVIOUS INTESTINES None	
190. PREVIOUS BLADDER None		191. PREVIOUS UTERUS None		192. PREVIOUS VAGINA None	
193. PREVIOUS PENIS None		194. PREVIOUS TESTES None		195. PREVIOUS PROSTATE None	
196. PREVIOUS THYROID None		197. PREVIOUS PARATHYROID None		198. PREVIOUS ADRENAL None	
199. PREVIOUS PITUITARY None		200. PREVIOUS HYPOTHYROID None		201. PREVIOUS DIAPHRAGM None	
202. PREVIOUS PERICARDIUM None		203. PREVIOUS ENDOMETRIUM None		204. PREVIOUS CERVIX None	
205. PREVIOUS VULVA None		206. PREVIOUS CLITORIS None		207. PREVIOUS GLANDS None	
208. PREVIOUS NERVES None		209. PREVIOUS MUSCLES None		210. PREVIOUS BONES None	
211. PREVIOUS JOINTS None		212. PREVIOUS SKELTON None		213. PREVIOUS DENTITION None	
214. PREVIOUS ORGANS None		215. PREVIOUS TISSUES None		216. PREVIOUS CELLS None	
217. PREVIOUS BLOOD None		218. PREVIOUS URINE None		219. PREVIOUS STOOL None	
220. PREVIOUS SWEAT None		221. PREVIOUS TEARS None		222. PREVIOUS SALIVA None	
223. PREVIOUS HAIR None		224. PREVIOUS NAILS None		225. PREVIOUS SKIN None	
226. PREVIOUS EYES None		227. PREVIOUS EARS None		228. PREVIOUS NOSE None	
229. PREVIOUS MOUTH None		230. PREVIOUS THROAT None		231. PREVIOUS LUNGS None	
232. PREVIOUS HEART None		233. PREVIOUS LIVER None		234. PREVIOUS SPLEEN None	
235. PREVIOUS PANCREAS None		236. PREVIOUS STOMACH None		237. PREVIOUS INTESTINES None	
238. PREVIOUS BLADDER None		239. PREVIOUS UTERUS None		240. PREVIOUS VAGINA None	
241. PREVIOUS PENIS None		242. PREVIOUS TESTES None		243. PREVIOUS PROSTATE None	
244. PREVIOUS THYROID None		245. PREVIOUS PARATHYROID None		246. PREVIOUS ADRENAL None	
247. PREVIOUS PITUITARY None		248. PREVIOUS HYPOTHYROID None		249. PREVIOUS DIAPHRAGM None	
250. PREVIOUS PERICARDIUM None		251. PREVIOUS ENDOMETRIUM None		252. PREVIOUS CERVIX None	
253. PREVIOUS VULVA None		254. PREVIOUS CLITORIS None		255. PREVIOUS GLANDS None	
256. PREVIOUS NERVES None		257. PREVIOUS MUSCLES None		258. PREVIOUS BONES None	
259. PREVIOUS JOINTS None		260. PREVIOUS SKELTON None		261. PREVIOUS DENTITION None	
262. PREVIOUS ORGANS None		263. PREVIOUS TISSUES None		264. PREVIOUS CELLS None	
265. PREVIOUS BLOOD None		266. PREVIOUS URINE None		267. PREVIOUS STOOL None	
268. PREVIOUS SWEAT None		269. PREVIOUS TEARS None		270. PREVIOUS SALIVA None	
271. PREVIOUS HAIR None		272. PREVIOUS NAILS None		273. PREVIOUS SKIN None	
274. PREVIOUS EYES None		275. PREVIOUS EARS None		276. PREVIOUS NOSE None	
277. PREVIOUS MOUTH None		278. PREVIOUS THROAT None		279. PREVIOUS LUNGS None	
280. PREVIOUS HEART None		281. PREVIOUS LIVER None		282. PREVIOUS SPLEEN None	
283. PREVIOUS PANCREAS None		284. PREVIOUS STOMACH None		285. PREVIOUS INTESTINES None	
286. PREVIOUS BLADDER None		287. PREVIOUS UTERUS None		288. PREVIOUS VAGINA None	
289. PREVIOUS PENIS None		290. PREVIOUS TESTES None		291. PREVIOUS PROSTATE None	
292. PREVIOUS THYROID None		293. PREVIOUS PARATHYROID None		294. PREVIOUS ADRENAL None	
295. PREVIOUS PITUITARY None		296. PREVIOUS HYPOTHYROID None		297. PREVIOUS DIAPHRAGM None	
298. PREVIOUS PERICARDIUM None		299. PREVIOUS ENDOMETRIUM None		300. PREVIOUS CERVIX None	
301. PREVIOUS VULVA None		302. PREVIOUS CLITORIS None		303. PREVIOUS GLANDS None	
304. PREVIOUS NERVES None		305. PREVIOUS MUSCLES None		306. PREVIOUS BONES None	
307. PREVIOUS JOINTS None		308. PREVIOUS SKELTON None		309. PREVIOUS DENTITION None	
310. PREVIOUS ORGANS None		311. PREVIOUS TISSUES None		312. PREVIOUS CELLS None	
313. PREVIOUS BLOOD None		314. PREVIOUS URINE None		315. PREVIOUS STOOL None	
316. PREVIOUS SWEAT None		317. PREVIOUS TEARS None		318. PREVIOUS SALIVA None	
319. PREVIOUS HAIR None		320. PREVIOUS NAILS None		321. PREVIOUS SKIN None	
322. PREVIOUS EYES None		323. PREVIOUS EARS None		324. PREVIOUS NOSE None	
325. PREVIOUS MOUTH None		326. PREVIOUS THROAT None		327. PREVIOUS LUNGS None	
328. PREVIOUS HEART None		329. PREVIOUS LIVER None		330. PREVIOUS SPLEEN None	
331. PREVIOUS PANCREAS None		332. PREVIOUS STOMACH None		333. PREVIOUS INTESTINES None	
334. PREVIOUS BLADDER None		335. PREVIOUS UTERUS None		336. PREVIOUS VAGINA None	
337. PREVIOUS PENIS None		338. PREVIOUS TESTES None		339. PREVIOUS PROSTATE None	
340. PREVIOUS THYROID None		341. PREVIOUS PARATHYROID None		342. PREVIOUS ADRENAL None	
343. PREVIOUS PITUITARY None		344. PREVIOUS HYPOTHYROID None		345. PREVIOUS DIAPHRAGM None	
346. PREVIOUS PERICARDIUM None		347. PREVIOUS ENDOMETRIUM None		348. PREVIOUS CERVIX None	
349. PREVIOUS VULVA None		350. PREVIOUS CLITORIS None		351. PREVIOUS GLANDS None	
352. PREVIOUS NERVES None		353. PREVIOUS MUSCLES None		354. PREVIOUS BONES None	
355. PREVIOUS JOINTS None		356. PREVIOUS SKELTON None		357. PREVIOUS DENTITION None	
358. PREVIOUS ORGANS None		359. PREVIOUS TISSUES None		360. PREVIOUS CELLS None	
361. PREVIOUS BLOOD None		362. PREVIOUS URINE None		363. PREVIOUS STOOL None	
364. PREVIOUS SWEAT None		365. PREVIOUS TEARS None		366. PREVIOUS SALIVA None	
367. PREVIOUS HAIR None		368. PREVIOUS NAILS None		369. PREVIOUS SKIN None	
370. PREVIOUS EYES None		371. PREVIOUS EARS None		372. PREVIOUS NOSE None	
373. PREVIOUS MOUTH None		374. PREVIOUS THROAT None		375. PREVIOUS LUNGS None	
376. PREVIOUS HEART None		377. PREVIOUS LIVER None		378. PREVIOUS SPLEEN None	
379. PREVIOUS PANCREAS None		380. PREVIOUS STOMACH None		381. PREVIOUS INTESTINES None	
382. PREVIOUS BLADDER None		383. PREVIOUS UTERUS None		384. PREVIOUS VAGINA None	
385. PREVIOUS PENIS None		386. PREVIOUS TESTES None		387. PREVIOUS PROSTATE None	
388. PREVIOUS THYROID None		389. PREVIOUS PARATHYROID None		390. PREVIOUS ADRENAL None	
391. PREVIOUS PITUITARY None		392. PREVIOUS HYPOTHYROID None		393. PREVIOUS DIAPHRAGM None	
394. PREVIOUS PERICARDIUM None		395. PREVIOUS ENDOMETRIUM None		396. PREVIOUS CERVIX None	
397. PREVIOUS VULVA None		398. PREVIOUS CLITORIS None		399. PREVIOUS GLANDS None	
400. PREVIOUS NERVES None		401. PREVIOUS MUSCLES None		402. PREVIOUS BONES None	
403. PREVIOUS JOINTS None		404. PREVIOUS SKELTON None		405. PREVIOUS DENTITION None	
406. PREVIOUS ORGANS None		407. PREVIOUS TISSUES None		408. PREVIOUS CELLS None	
409. PREVIOUS BLOOD None		410. PREVIOUS URINE None		411. PREVIOUS STOOL None	
412. PREVIOUS SWEAT None		413. PREVIOUS TEARS None		414. PREVIOUS SALIVA None	
415. PREVIOUS HAIR None		416. PREVIOUS NAILS None		417. PREVIOUS SKIN None	
418. PREVIOUS EYES None		419. PREVIOUS EARS None		420. PREVIOUS NOSE None	
421. PREVIOUS MOUTH None		422. PREVIOUS THROAT None		423. PREVIOUS LUNGS None	
424. PREVIOUS HEART None		425. PREVIOUS LIVER None		426. PREVIOUS SPLEEN None	
427. PREVIOUS PANCREAS None		428. PREVIOUS STOMACH None		429. PREVIOUS INTESTINES None	
430. PREVIOUS BLADDER None		431. PREVIOUS UTERUS None		432. PREVIOUS VAGINA None	
433. PREVIOUS PENIS None		434. PREVIOUS TESTES None		435. PREVIOUS PROSTATE None	
436. PREVIOUS THYROID None		437. PREVIOUS PARATHYROID None		438. PREVIOUS ADRENAL None	
439. PREVIOUS PITUITARY None		440. PREVIOUS HYPOTHYROID None		441. PREVIOUS DIAPHRAGM None	
442. PREVIOUS PERICARDIUM None		443. PREVIOUS ENDOMETRIUM None		444. PREVIOUS CERVIX None	
445. PREVIOUS VULVA None		446. PREVIOUS CLITORIS None		447. PREVIOUS GLANDS None	
448. PREVIOUS NERVES None		449. PREVIOUS MUSCLES None		450. PREVIOUS BONES None	
451. PREVIOUS JOINTS None		452. PREVIOUS SKELTON None		453. PREVIOUS DENTITION None	
454. PREVIOUS ORGANS None		455. PREVIOUS TISSUES None		456. PREVIOUS CELLS None	
457. PREVIOUS BLOOD None		458. PREVIOUS URINE None		459. PREVIOUS STOOL None	
460. PREVIOUS SWEAT None		461. PREVIOUS TEARS None		462. PREVIOUS SALIVA None	
463. PREVIOUS HAIR None		464. PREVIOUS NAILS None		465. PREVIOUS SKIN None	
466. PREVIOUS EYES None		467. PREVIOUS EARS None		468. PREVIOUS NOSE None	
469. PREVIOUS MOUTH None		470. PREVIOUS THROAT None		471. PREVIOUS LUNGS None	
472. PREVIOUS HEART None		473. PREVIOUS LIVER None		474. PREVIOUS SPLEEN None	
475. PREVIOUS PANCREAS None		476. PREVIOUS STOMACH None		477. PREVIOUS INTESTINES None	
478. PREVIOUS BLADDER None		479. PREVIOUS UTERUS None		480. PREVIOUS VAGINA None	
481. PREVIOUS PENIS None		482. PREVIOUS TESTES None		483. PREVIOUS PROSTATE None	
484. PREVIOUS THYROID None		485. PREVIOUS PARATHYROID None		486. PREVIOUS ADRENAL None	
487. PREVIOUS PITUITARY None		488. PREVIOUS HYPOTHYROID None		489. PREVIOUS DIAPHRAGM None	
490. PREVIOUS PERICARDIUM None		491. PREVIOUS ENDOMETRIUM None		492. PREVIOUS CERVIX None	
493. PREVIOUS VULVA None		494. PREVIOUS CLITORIS None		495. PREVIOUS GLANDS None	
496. PREVIOUS NERVES None		497. PREVIOUS MUSCLES None		498. PREVIOUS BONES None	
499. PREVIOUS JOINTS None		500. PREVIOUS SKELTON None		501. PREVIOUS DENTITION None	
502. PREVIOUS ORGANS None		503. PREVIOUS TISSUES None		504. PREVIOUS CELLS None	
505. PREVIOUS BLOOD None		506. PREVIOUS URINE None		507. PREVIOUS STOOL None	
508. PREVIOUS SWEAT None		509. PREVIOUS TEARS None		510. PREVIOUS SALIVA None	
511. PREVIOUS HAIR None		512. PREVIOUS NAILS None		513. PREVIOUS SKIN None	
514. PREVIOUS EYES None		515. PREVIOUS EARS None		516. PREVIOUS NOSE None	
517. PREVIOUS MOUTH None		518. PREVIOUS THROAT None		519. PREVIOUS LUNGS None	
520. PREVIOUS HEART None		521. PREVIOUS LIVER None		522. PREVIOUS SPLEEN None	
523. PREVIOUS PANCREAS None		524. PREVIOUS STOMACH None		525. PREVIOUS INTESTINES None	
526. PREVIOUS BLADDER None		527. PREVIOUS UTERUS None		528. PREVIOUS VAGINA None	
529. PREVIOUS PENIS None		530. PREVIOUS TESTES None		531. PREVIOUS PROSTATE None	
532. PREVIOUS THYROID None		533. PREVIOUS PARATHYROID None		534. PREVIOUS ADRENAL None	
535. PREVIOUS PITUITARY None		536. PREVIOUS HYPOTHYROID None		537. PREVIOUS DIAPHRAGM None	
538. PREVIOUS PERICARDIUM None		539. PREVIOUS ENDOMETRIUM None		540. PREVIOUS CERVIX None	
541. PREVIOUS VULVA None		542. PREVIOUS CLITORIS None		543. PREVIOUS GLANDS None	
544. PREVIOUS NERVES None		545. PREVIOUS MUSCLES None		546. PREVIOUS BONES None	
547. PREVIOUS JOINTS None		548. PREVIOUS SKELTON None		549. PREVIOUS DENTITION None	
550. PREVIOUS ORGANS None		551. PREVIOUS TISSUES None		552. PREVIOUS CELLS None	
553. PREVIOUS BLOOD None		554. PREVIOUS URINE None		555. PREVIOUS STOOL None	
556. PREVIOUS SWEAT None		557. PREVIOUS TEARS None		558. PREVIOUS SALIVA None	
559. PREVIOUS HAIR None		560. PREVIOUS NAILS None		561. PREVIOUS SKIN None	
562. PREVIOUS EYES None		563. PREVIOUS EARS None		564. PREVIOUS NOSE None	
565. PREVIOUS MOUTH None		566. PREVIOUS THROAT None		567. PREVIOUS LUNGS None	
568. PREVIOUS HEART None		569. PREVIOUS LIVER None		570. PREVIOUS SPLEEN None	
571. PREVIOUS PANCREAS None		572. PREVIOUS STOMACH None		573. PREVIOUS INTESTINES None	
574. PREVIOUS BLADDER None		575. PREVIOUS UTERUS None		576. PREVIOUS VAGINA None	
577. PREVIOUS PENIS None		578. PREVIOUS TESTES None		579. PREVIOUS PROSTATE None	
580. PREVIOUS THYROID None		581. PREVIOUS PARATHYROID None		582. PREVIOUS ADRENAL None	
583. PREVIOUS PITUIT					

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02613

2652

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Odenton</u>		c. LENGTH OF STAY IN 1b <u>10 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Annapolis Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Andrew</u> Middle <u>J.</u> Last <u>Disney-Jr.</u>		4. DATE OF DEATH Month <u>March</u> Day <u>29</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 21-1872</u>
9. AGE (In years lost birthday) <u>86 yrs.</u>		10. IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Blacksmiths-Helpers</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B &amp; A P.R.</u>	
11. BIRTHPLACE (State or foreign country) <u>Anne Arundel Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Andrew J. Disney - Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Harriett K. Redmiles</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <u>NO</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Kenneth L. Disney - Same as No. 2</u>		Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute fatal pneumonia</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardiovascular Disease</u> DUE TO <u>Generalized arteriosclerosis</u> (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>1 year</u> <u>3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senility</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Jan 15-</u> , 19 <u>59</u> , to <u>March 28-</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>March 28-59</u> , 19 <u>59</u> , and that death occurred at <u>5:30 p.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph Lipskey</u> M.D.		ADDRESS (Street, city or town, state) <u>Anne Arundel - Md.</u>	
PHYSICIAN'S NAME (Type) <u>JOSEPH LIPSKEY</u>		DATE SIGNED <u>3-30-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/31/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Friendship Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Anne Arundel - Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard W. Lighter</u>		ADDRESS <u>Stanton, Bowie, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>APR 1 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







2607

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANNAPOLIS</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>ANNE ARUNDEL GENERAL HOSPITAL</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GAMBRILLS</b> d. STREET ADDRESS <b>1</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>FRANCES DOLJAN</b>			4. DATE OF DEATH Month Day Year <b>MARCH 11 19 59</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 16, 1881</b>	9. AGE (In years, last birthday) <b>77</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (State or foreign country) <b>Germany</b>			
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mr. Joseph Doljan Jr Son Same as # 2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1 Congestive Heart Failure</b> DUE TO (b) <b>Intensive Arterio Cardio Vascular</b> DUE TO (c) <b>disorder</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <b>2 wks.</b> <b>yes.</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <b>then 4</b> , 19 <b>53</b> to <b>March 11, 1959</b> , that I last saw the deceased alive on <b>March 11, 1959</b> , and that death occurred at <b>11:30 A</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Maurice F. Klawans</b> M.D.			DATE SIGNED <b>March 12, 1959</b>				
PHYSICIAN'S NAME (Type) <b>Maurice F. Klawans MD</b>			<b>31 Southgate Ave. Annapolis, Md.</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3-14-1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Annapolis, Maryland</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping Funeral Home</b> ADDRESS <b>Annapolis, Maryland</b>			24a. REC'D BY REGISTRAR <b>DATE 16 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Krawe</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 or 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

2000

DATE OF DEATH

TIME

PLACE

CAUSE

MANNER

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEPARTURE

PLACE OF DEPARTURE

DATE OF RETURN

PLACE OF RETURN

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**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## CERTIFICATE OF DEATH

2653

Item 4 FilmG239 3-16-59 et

Reg. Dist. No. ....

02613

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Anne Arundel</u> MARYLAND				STATE <u>Maryland</u> COUNTY <u>—</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>GLEN BURNIE</u>				CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>BALT. MORE 3V01-4</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>204 CARROLL Rd.</u>				STREET ADDRESS (If rural give location) <u>419 S. BENTALOU ST.</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>LOLA GERTRUDE DORSEY</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>March 8, 19 59</u>			
<b>5. SEX</b> <u>FEMALE</u>	<b>6. COLOR OR RACE</b> <u>WHITE</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED,</b> (Specify) <u>WIDOWED</u>	<b>8. DATE OF BIRTH</b> <u>JANUARY 12, 1883</u>	<b>9. AGE last birthday</b> <u>76</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		<b>IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Domestic</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Virginia</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>DOUGLAS MARTIN</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>MARGARET JOHNSON</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b> <u>NONE</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>ALMER DORSEY 419 S. BENTALOU ST.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>157X IMMEDIATE CAUSE</b> (A) <u>Calcemia of Pancreas</u>						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>4 months</u>	
<b>ANTECEDENT CAUSE(S)</b> DUE TO							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE</b> DUE TO							
<b>STATING UNDERLYING CAUSE LAST.</b> DUE TO							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, notify medical examiner)		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)		<b>21a. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <u>11/20</u> , 19 <u>53</u> , to <u>4/8</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3/1/59</u> , 19 <u>59</u> , and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above.							
<b>SIGNATURE</b> <u>Paul Schufeldt</u>				<b>ADDRESS</b> (Street, city, town, state) <u>Boi Annapolis</u>		<b>DATE SIGNED</b> <u>3/4/59</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>BURIAL</u>		<b>DATE THEREOF</b> <u>3/11/59</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>WOODLAWN</u>		<b>LOCATION (City, town, or county)</b> <u>Woodlawn Md.</u>	
<b>24. REC'D BY REGISTRAR</b> <u>MAR 11 '59</u>		<b>REGISTRAR'S SIGNATURE</b> <u>Arthur S. Evans</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Geo. L. Schwab Funeral Home</u>		<b>ADDRESS</b> <u>Baltimore 2101 Frederick Ave</u>	

# CERTIFICATE OF DEATH

NO. 100-100

2023

1. DECEASED PERSON'S NAME OR NAME

NAME AND

DATE OF

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2. MENTAL DECLARATION

STATE OF MARYLAND  
COUNTY OF BALTIMORE  
I, the undersigned, being a duly qualified medical practitioner, do hereby certify that the above named person died on the \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_, at the place of death above stated, and that the cause of death was \_\_\_\_\_.

Witness my hand and seal this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_.

\_\_\_\_\_  
Medical Practitioner

\_\_\_\_\_  
Physician

\_\_\_\_\_  
Physician

\_\_\_\_\_  
Physician

\_\_\_\_\_  
Physician

2007-2010



RECEIVED  
MAY 15 19\_\_\_\_

2654

## CERTIFICATE OF DEATH

02616

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riva</u>				c. LENGTH OF STAY IN IB			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Riva Nursing Home</u>				d. STREET ADDRESS <u>Arnold</u>			
3. NAME OF DECEASED (Type or print) First <u>RHODA</u> Middle <u>DULL</u> Last <u>DULL</u>				4. DATE OF DEATH Month <u>March</u> Day <u>4</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Caucasian</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 4, 1878</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		11. IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Waynesborough, Virginia</u>	
13. FATHER'S NAME <u>SIRAS BROWN</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>  </u>				16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Mr Lurty Dull Sr- Son</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> 332 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> DUE TO (c) <u>  </u>				INTERVAL BETWEEN ONSET AND DEATH <u>60 Hours</u> <u>UNKNOWN</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month <u>  </u> Day <u>  </u> Year <u>1959</u> Hour <u>  </u> o. m. <u>  </u> p. m. <u>  </u>			
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) <u>  </u>				20g. (County) <u>  </u>			
20h. (State) <u>  </u>				21. I certify that I attended the deceased from <u>15 JAN 1959</u> , to <u>4 MARCH 1959</u> , that I last saw the deceased alive on <u>3 MAR 1959</u> , and that death occurred at <u>11 A</u> M, from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <u>  </u>				DATE SIGNED <u>  </u>			
ACTUAL SIGNATURE <u>Edward S Beck</u> M.D.				PHYSICIAN'S NAME (Type) <u>EDWARD S BECK, M.D.,</u>			
ADDRESS <u>41 Southgate Ave, Annapolis, Maryland</u>				22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			
22b. DATE THEREOF <u>March 7, 1959</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff</u>			
22d. LOCATION (City, town, or county) <u>Annapolis, Maryland</u>				22e. (State) <u>  </u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOPPING FUNERAL HOME</u>				ADDRESS <u>Annapolis, Maryland</u>			
24a. REC'D BY REGISTRAR <u>MAR 9 '59</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

452



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02617

2608

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANNAPOLIS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EDGEWATER</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>ANNE ARUNDEL</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JAMES RINGGOLD DUVALL</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>27</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 17, 1895</b>
9. AGE (In years last birthday) <b>64 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Caretaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	
11. BIRTHPLACE (State or foreign country) <b>Edgewater, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>RINGGOLD DUVALL</b>		14. MOTHER'S MAIDEN NAME <b>MARY WILLARD</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>E. Saunders Duvall- Brother- Annapolis, Maryland</b>		Address <b>Steele Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1-2-3 rd mass 60 to body -</b> <b>916.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>stroke</b> (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <b>9 days</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>attempting to push out back fence</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>3-19-1959</b> p. m. <b>3-19-1959</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Elmer G. Linhardt MD</b>		DATE SIGNED <b>3/27/59</b>	
EXAMINER'S NAME (Type) <b>Elmer G. Linhardt MD</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 30, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Salem Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Annapolis, Maryland</b>	
24a. REC'D BY REGISTRAR <b>APR 1 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Howard</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 1, 2, and 3 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



2655

## CERTIFICATE OF DEATH

02618

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ft Geo. G. Meade</u>				c. LENGTH OF STAY IN 1b <u>1 Day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severn</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>USAH Ft Geo. G. Meade, Md</u>				d. STREET ADDRESS <u>425 Thompson Ave</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>(Infant) Donald</u> Middle <u>R.</u> Last <u>Engle</u>		4. DATE OF DEATH Month <u>March</u> Day <u>24</u> Year <u>1959</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>24 March 1959</u>	9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>1</u> Hours <u>1</u> Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Donald R Engle</u>				14. MOTHER'S MAIDEN NAME <u>Patricia J. Stuckey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Donald R. Engle, 425 Thompson Ave, Severn, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> DUE TO <u>Micrognathia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pierre Robin Syndrome - Cleft Palate</u> DUE TO <u>Glossoptosis</u> (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>24 March</u> , 19 <u>59</u> , to <u>24 March</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>24 March</u> , 19 <u>59</u> , and that death occurred at <u>5:30 P</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <u>Fred W. Lafferty</u> M.D.		3/24/59					
PHYSICIAN'S NAME (Type) <u>FREDERICK W LAFFERTY</u> Captain MC		U. S. ARMY HOSPITAL, FT MEADE, MD					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	22b. DATE THEREOF <u>3-27-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Springfield Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Springfield, Ohio</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1217 St. Paul Strett</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 30 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please place carbon papers. Pages 1 and 2 should be filed with the registry prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 could be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2609

## CERTIFICATE OF DEATH

Reg. Dist. No.

02619

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Anne Arundel General Hospital</u>		1. d. STREET ADDRESS <u>415 Chester Street</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Forrester</u>		4. DATE OF DEATH Month Day Year <u>March 18 19 59</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 18, 1959</u>
9. AGE (In years lost birthday) yrs. <u>10</u> Months <u>5</u> Days <u>10</u> Mins. <u>55</u>		10. IF UNDER 1 YEAR Months Days Hours Mins.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Bernard Albert Forrester</u>		14. MOTHER'S MAIDEN NAME <u>Doris Pauline Booth</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT Address <u>Mother, 415 Chester Ave., Annapolis, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776x</u> DUE TO <u>Prematurity</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs 55 min</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 18, 1959</u> to <u>March 18, 1959</u> , that I last saw the deceased alive on <u>March 18, 1959</u> , and that death occurred at <u>1:45 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul H. Sims M.D.</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>95 Cathedral St. Annapolis, Md. 3/24/59</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-24-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Reese #108 Wash St. Annapolis Md</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 26 '59</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thane</u>	

10801

CERTIFICATE OF DEATH

10801

DO NOT WRITE IN THESE SPACES

NAME OF DECEASED

DATE OF DEATH

1. Name of Deceased	
2. Date of Death	
3. Place of Death	
4. Cause of Death	
5. Signature of Physician	
6. Signature of Registrar	
7. Date of Registration	
8. Place of Registration	
9. Name of Registrar	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2610

## CERTIFICATE OF DEATH

02620

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>AA</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>AA</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis Md</i>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>U. S. General</i>				d. STREET ADDRESS <i>141 Murray Ave</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <i>Clarence</i> Middle <i>E.</i> Last <i>Fouche</i>				4. DATE OF DEATH Month <i>MARCH</i> Day <i>6</i> Year <i>1959</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>June 14<sup>th</sup> 1885</i>	
9. AGE (In years last birthday) <i>73</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Plumber</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Plumber</i>		11. BIRTHPLACE (State or foreign country) <i>Annapolis Md</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>							
13. FATHER'S NAME <i>John R. Fouche</i>				14. MOTHER'S MAIDEN NAME <i>Annie R. Medford</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <i>Ella M. Fouche</i> Address <i>(2)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary artery atherosclerosis</i> DUE TO (c) <i>Renal lithiasis</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Renal lithiasis</i> INTERVAL BETWEEN ONSET AND DEATH <i>5 yrs</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Sept</i> , 1957, to <i>March 6</i> , 1959, that I last saw the deceased alive on <i>March 6</i> , 1959, and that death occurred at <i>12:30</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>121 Cathedral</i> DATE SIGNED <i>3/6/59</i> ACTUAL SIGNATURE <i>John L. Hederman</i> M.D. <i>Annapolis Md.</i> PHYSICIAN'S NAME (Type) <i>Annapolis Md.</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3-9-59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Hillcrest Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Annapolis Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Scully Succ</i> ADDRESS <i>Annapolis Md.</i>				24a. REC'D BY REGISTRAR <i>MAR 11 1959</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Frank</i>	



2656

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN 1b <b>2mo 10days</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Easton</b> 2040.2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>		d. STREET ADDRESS <b>Unknown</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>William</b>		First <b>William</b>		Middle <b>Fountain</b>		Last <b>Fountain</b>	
4. DATE OF DEATH Month <b>3</b> Day <b>4</b> Year <b>19 59</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>1880</b>		9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months <b>78</b>		IF UNDER 24 HRS. Days <b>78</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>		11. BIRTHPLACE (State or foreign country) <b>Unknown</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>214-10-0613</b>	
17. INFORMANT <b>Hospital Records</b>		Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>570.5</b> DUE TO <b>Starvation and Dehydration</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Post Surgical — Intestinal Obstruction</b> (c) <b>Inter Trochanteric Fracture Right Hip</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>002X Pulmonary Tuberculosis — Senility — Syphilis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>-----</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-----</b>		20f. (City or town) <b>-----</b> (County) <b>-----</b> (State) <b>-----</b>	
21. I certify that I attended the deceased from <b>12/24</b> 19 <b>58</b> , to <b>3/4/59</b> , that I last saw the deceased alive on <b>3/4/59</b> and that death occurred at <b>10:30P.</b> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Crownsville State Hospital, Md.</b>		DATE SIGNED <b>3/5/59</b>			
ACTUAL SIGNATURE <b>Lionel McHenry Mapp</b>		M.D. <b>Crownsville State Hospital, Md.</b>		DATE SIGNED <b>3/5/59</b>			
PHYSICIAN'S NAME (Type) <b>Lionel McHenry Mapp, M. D.</b>		ADDRESS <b>Crownsville State Hospital, Md.</b>		DATE SIGNED <b>3/5/59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>March 12/59</b>		22b. DATE THEREOF <b>March 12/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Bell's Chapel</b>		22d. LOCATION (City, town, or county) <b>Crownsville</b> (State) <b>Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. F. Moore &amp; Son</b>		ADDRESS <b>Benton Md</b>		24a. REC'D BY REGISTRAR <b>DATE MAR 13 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3058

MARYLAND STATE DEPARTMENT OF HEALTH

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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>aa</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>aa</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>129 Monticello Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Henry</u> Last <u>French</u>				4. DATE OF DEATH Month <u>3</u> Day <u>6</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 21-1894</u>	
				9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mgr. Circulation Dept. Newspaper Business</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Norfolk Va</u>			
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>William N. French</u>				14. MOTHER'S MAIDEN NAME <u>Minnie Woolhiser</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give year or date of service) <u>World War I</u>				16. SOCIAL SECURITY NO. <u>-</u>			
17. INFORMANT <u>Lillie L. French</u> Address <u>(2)</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY THROMBOSIS</u> DUE TO (c) <u>ARTERIOSCLEROTIC CORONARY ART. DIS.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 Hour</u> <u>1 Hour</u> <u>Unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>HYPERTENSION, MODERATE</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>2/16</u> , 19 <u>59</u> , to <u>3/6</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3/2</u> , 19 <u>59</u> , and that death occurred at <u>11:30 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edward S. Beck</u> M.D. <u>41 Southgate Ave</u>				DATE SIGNED <u>3/7/59</u>			
PHYSICIAN'S NAME (Type) <u>EDWARD S. BECK MD ANNAPOLIS, MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar-9-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Grove</u>		22d. LOCATION (City, town, or county) (State) <u>Norfolk Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u> ADDRESS <u>Annapolis Md.</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 11 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>	

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2657

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b> c. LENGTH OF STAY IN 1b <b>29yrs. 2mo. 10d</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore,</b> d. STREET ADDRESS <b>826 Tessier Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Ida</b>		First <b>Ida</b>		Middle <b>Gabriel</b>		Last <b>Gabriel</b>		4. DATE OF DEATH Month <b>3</b> Day <b>20</b> Year <b>19 59</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1882</b>		9. AGE (In years last birthday) yrs. <b>77</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Houseworker</b>		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>John Cole</b>				14. MOTHER'S MAIDEN NAME <b>Sarah</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Hospital Records</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Senile Atrophy</b> DUE TO <b>Generalized Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cellulitis of the Right Hand</b>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>1/10</u> , 19 <u>30</u> , to <u>3/20</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3/20</u> , 19 <u>59</u> , and that death occurred at <u>12:45 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Crownsville State Hospital, Md.</b> DATE SIGNED <b>3/20/59</b> ACTUAL SIGNATURE <i>L. Benedict</i> M.D. <b>Crownsville State Hospital, Md.</b> 3/20/59 PHYSICIAN'S NAME (Type) <b>L. Benedict, M. D.</b> <b>Crownsville State Hospital, Md.</b> 3/20/59									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>3-26-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Anatomy Board of Md.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>John P. E. II</i>				ADDRESS		24a. REC'D BY REGISTRAR DATE <b>APR 2 '59</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. H. H.</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2027

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

125023

*Handwritten signature*

DEC 8 1918

2612

## CERTIFICATE OF DEATH

02624

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>AA</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>AA</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Ch. U. General Hospital</i>				e. STREET ADDRESS <i>Arundel Road R7D. #3</i>			
3. NAME OF DECEASED (Type or print) First <i>Helen</i> Middle <i>Bain</i> Last <i>Gray</i>				4. DATE OF DEATH Month <i>3</i> - Day <i>29</i> Year <i>1959</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>June 29-1900</i>	
9. AGE (In years last birthday) <i>58</i> yrs.		IF UNDER 1 YEAR Months <i>3</i> Days <i>29</i> Hours <i>19</i> Min.		IF UNDER 24 HRS. Months <i>3</i> Days <i>29</i> Hours <i>19</i> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTH PLACE (State or foreign country) <i>Scotland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>							
13. FATHER'S NAME <i>Robert Bain</i>				14. MOTHER'S MAIDEN NAME <i>Helen Seth</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <i>John Gray</i> Address <i>(2)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinomatous</i> <i>199.2</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>May</i> , 1955, to <i>March</i> , 1959, that I last saw the deceased alive on <i>March 29</i> , 1959, and that death occurred at <i>12:00</i> P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>121 Cathedral</i> DATE SIGNED <i>3/31/59</i> ACTUAL SIGNATURE <i>John L. Hadenman</i> M.D. PHYSICIAN'S NAME (Type) <i>Annapolis Md</i>							
22a. BURIAL, CREMATION, or MOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Apr 1-59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Hillcrest Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Annapolis Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Layton</i> ADDRESS <i>Sus Annapolis Md</i>				24a. REC'D BY REGISTRAR DATE <i>APR 2 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2613

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>H.A. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. LENGTH OF STAY IN 1b <u>10</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>513 1st St.</u>		d. STREET ADDRESS <u>33 EASTERN AVE.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>SUSAN</u> Middle <u>K.</u> Last <u>HANCOCK</u>		4. DATE OF DEATH Month <u>3</u> Day <u>27</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-28-1881</u>
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ANDREW J. MEUTH</u>		14. MOTHER'S MAIDEN NAME <u>KATHERINE HOOVER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service) <u></u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>WALTER HANCOCK</u>		Address <u>#2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>azotemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerotic heart disease</u> DUE TO <u></u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>1 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 4, 1959</u> to <u>Jan. 27, 1959</u> , that I last saw the deceased alive on <u>3-26-59</u> , 1959, and that death occurred at <u>5:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James R. Martin</u> M.D.		DATE SIGNED <u>3/27/59</u>	
PHYSICIAN'S NAME (Type) <u>JAMES R. MARTIN</u>		<u>65 HAW ST ANNAPOLIS, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>3-29-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR BLUFF</u>	22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor &amp; Sons</u>		ADDRESS <u>Annapolis, Md.</u>	
24a. REC'D BY REGISTRAR <u>MAR 30 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton S. Hume</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 could be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02627

2614

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>aa</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>aa</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>10 Annapolis</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>48 Franklin St</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Jeanne</i> Middle <i>J.</i> Last <i>Herron</i>		4. DATE OF DEATH Month <i>3</i> Day <i>3</i> Year <i>1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept 21-1908</i>
9. AGE (In years last birthday) yrs. <i>50</i>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Elmer Martin Jackson Sr.</i>		14. MOTHER'S MAIDEN NAME <i>Blanche Beatrice Power</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <i>-</i>	
17. INFORMANT <i>Robert J. Herron</i>		Address <i>(2)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute coronary heart disease</i> <i>252.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>cardiac strain</i> DUE TO (c) <i>thyrotoxicosis</i> INTERVAL BETWEEN ONSET AND DEATH <i>10 years</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>2-29-56</i> , 19 <i>56</i> , to <i>3-3</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>2-16</i> , 19 <i>59</i> , and that death occurred at <i>21</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>45 Franklin St. Annapolis Md</i> DATE SIGNED <i>3-5-59</i>			
ACTUAL SIGNATURE <i>Edith Rodler M.D.</i>		M.D. <i>45 Franklin St. Annapolis Md</i>	
PHYSICIAN'S NAME (Type) <i>EDITH RODLER M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>3-6-59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Naval Academy Cent</i>	22d. LOCATION (City, town, or county) (State) <i>Annapolis Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sns</i>		ADDRESS <i>Annapolis Md</i>	
24a. REC'D BY REGISTRAR DATE <i>MAR 9 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. House</i>	

CERTIFICATE OF DEATH

2010

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>65</i>	
4. DATE OF DEATH <i>Jan 15 2010</i>		5. TIME OF DEATH <i>10:00 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. MANNER OF DEATH <i>Natural</i>		9. PLACE OF BIRTH <i>Baltimore, MD</i>	
10. DATE OF BIRTH <i>Jan 1 1945</i>		11. SEX OF BIRTH <i>Male</i>		12. AGE AT BIRTH <i>65</i>	
13. DATE OF DEATH <i>Jan 15 2010</i>		14. TIME OF DEATH <i>10:00 AM</i>		15. PLACE OF DEATH <i>Home</i>	
16. CAUSE OF DEATH <i>Heart Disease</i>		17. MANNER OF DEATH <i>Natural</i>		18. PLACE OF BIRTH <i>Baltimore, MD</i>	
19. DATE OF BIRTH <i>Jan 1 1945</i>		20. SEX OF BIRTH <i>Male</i>		21. AGE AT BIRTH <i>65</i>	
22. DATE OF DEATH <i>Jan 15 2010</i>		23. TIME OF DEATH <i>10:00 AM</i>		24. PLACE OF DEATH <i>Home</i>	
25. CAUSE OF DEATH <i>Heart Disease</i>		26. MANNER OF DEATH <i>Natural</i>		27. PLACE OF BIRTH <i>Baltimore, MD</i>	
28. DATE OF BIRTH <i>Jan 1 1945</i>		29. SEX OF BIRTH <i>Male</i>		30. AGE AT BIRTH <i>65</i>	
31. DATE OF DEATH <i>Jan 15 2010</i>		32. TIME OF DEATH <i>10:00 AM</i>		33. PLACE OF DEATH <i>Home</i>	
34. CAUSE OF DEATH <i>Heart Disease</i>		35. MANNER OF DEATH <i>Natural</i>		36. PLACE OF BIRTH <i>Baltimore, MD</i>	
37. DATE OF BIRTH <i>Jan 1 1945</i>		38. SEX OF BIRTH <i>Male</i>		39. AGE AT BIRTH <i>65</i>	
40. DATE OF DEATH <i>Jan 15 2010</i>		41. TIME OF DEATH <i>10:00 AM</i>		42. PLACE OF DEATH <i>Home</i>	
43. CAUSE OF DEATH <i>Heart Disease</i>		44. MANNER OF DEATH <i>Natural</i>		45. PLACE OF BIRTH <i>Baltimore, MD</i>	
46. DATE OF BIRTH <i>Jan 1 1945</i>		47. SEX OF BIRTH <i>Male</i>		48. AGE AT BIRTH <i>65</i>	
49. DATE OF DEATH <i>Jan 15 2010</i>		50. TIME OF DEATH <i>10:00 AM</i>		51. PLACE OF DEATH <i>Home</i>	
52. CAUSE OF DEATH <i>Heart Disease</i>		53. MANNER OF DEATH <i>Natural</i>		54. PLACE OF BIRTH <i>Baltimore, MD</i>	
55. DATE OF BIRTH <i>Jan 1 1945</i>		56. SEX OF BIRTH <i>Male</i>		57. AGE AT BIRTH <i>65</i>	
58. DATE OF DEATH <i>Jan 15 2010</i>		59. TIME OF DEATH <i>10:00 AM</i>		60. PLACE OF DEATH <i>Home</i>	
61. CAUSE OF DEATH <i>Heart Disease</i>		62. MANNER OF DEATH <i>Natural</i>		63. PLACE OF BIRTH <i>Baltimore, MD</i>	
64. DATE OF BIRTH <i>Jan 1 1945</i>		65. SEX OF BIRTH <i>Male</i>		66. AGE AT BIRTH <i>65</i>	
67. DATE OF DEATH <i>Jan 15 2010</i>		68. TIME OF DEATH <i>10:00 AM</i>		69. PLACE OF DEATH <i>Home</i>	
70. CAUSE OF DEATH <i>Heart Disease</i>		71. MANNER OF DEATH <i>Natural</i>		72. PLACE OF BIRTH <i>Baltimore, MD</i>	
73. DATE OF BIRTH <i>Jan 1 1945</i>		74. SEX OF BIRTH <i>Male</i>		75. AGE AT BIRTH <i>65</i>	
76. DATE OF DEATH <i>Jan 15 2010</i>		77. TIME OF DEATH <i>10:00 AM</i>		78. PLACE OF DEATH <i>Home</i>	
79. CAUSE OF DEATH <i>Heart Disease</i>		80. MANNER OF DEATH <i>Natural</i>		81. PLACE OF BIRTH <i>Baltimore, MD</i>	
82. DATE OF BIRTH <i>Jan 1 1945</i>		83. SEX OF BIRTH <i>Male</i>		84. AGE AT BIRTH <i>65</i>	
85. DATE OF DEATH <i>Jan 15 2010</i>		86. TIME OF DEATH <i>10:00 AM</i>		87. PLACE OF DEATH <i>Home</i>	
88. CAUSE OF DEATH <i>Heart Disease</i>		89. MANNER OF DEATH <i>Natural</i>		90. PLACE OF BIRTH <i>Baltimore, MD</i>	
91. DATE OF BIRTH <i>Jan 1 1945</i>		92. SEX OF BIRTH <i>Male</i>		93. AGE AT BIRTH <i>65</i>	
94. DATE OF DEATH <i>Jan 15 2010</i>		95. TIME OF DEATH <i>10:00 AM</i>		96. PLACE OF DEATH <i>Home</i>	
97. CAUSE OF DEATH <i>Heart Disease</i>		98. MANNER OF DEATH <i>Natural</i>		99. PLACE OF BIRTH <i>Baltimore, MD</i>	
100. DATE OF BIRTH <i>Jan 1 1945</i>		101. SEX OF BIRTH <i>Male</i>		102. AGE AT BIRTH <i>65</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02628

2615

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>C. C.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>10 Annapolis, Md.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>917 West St.</i>		d. STREET ADDRESS <i>1 917 West St.</i>	
3. NAME OF DECEASED (Type or print) <i>Michael John Holland</i>		4. DATE OF DEATH Month <i>3</i> Day <i>8</i> Year <i>1959</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Col.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-2-1955</i>
9. AGE (in years last birthday) <i>4</i> yrs.		IF UNDER 1 YEAR Months <i></i> Days <i></i>	IF UNDER 24 HRS. Hours <i></i> Min. <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>John Holland</i>		14. MOTHER'S MAIDEN NAME <i>Adele Randall</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i></i>	
17. INFORMANT <i>John Holland, Annapolis, Md.</i>		Address <i>Annapolis, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Burns generalized</i> <i>916.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Sudden</i> DUE TO (c) <i></i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i></i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Same line</i>	
20c. TIME OF INJURY Month, Day, Year Hour <i>a. m.</i> <i>3/8/59</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>		20f. (City or town) (County) (State) <i>Annapolis, Md.</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John Holland</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>F. L. HART</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3-11-59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Brewer Hill</i>		22d. LOCATION (City, town, or county) (State) <i>Annapolis, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese, Jr. - Annapolis, Md.</i>		24a. REC'D BY REGISTRAR <i>Arthur L. Harris</i>	
ADDRESS <i>Annapolis, Md.</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Harris</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03682

1. NAME OF DECEASED: \_\_\_\_\_

2. SEX: ☐ MALE ☐ FEMALE

3. AGE: \_\_\_\_\_

4. DATE OF BIRTH: \_\_\_\_\_

5. PLACE OF BIRTH: \_\_\_\_\_

6. OCCUPATION: \_\_\_\_\_

7. MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED

8. PRESENT ADDRESS: \_\_\_\_\_

9. DATE OF DEATH: \_\_\_\_\_

10. TIME OF DEATH: \_\_\_\_\_

11. PLACE OF DEATH: \_\_\_\_\_

12. CAUSE OF DEATH: \_\_\_\_\_

13. MANNER OF DEATH: ☐ NATURAL ☐ ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐ UNDETERMINED

14. SIGNATURE OF MEDICAL EXAMINER: \_\_\_\_\_

15. SIGNATURE OF WITNESS: \_\_\_\_\_

16. SIGNATURE OF CORONER: \_\_\_\_\_

17. SIGNATURE OF JURY: \_\_\_\_\_

18. SIGNATURE OF DECEASED: \_\_\_\_\_

19. SIGNATURE OF NEXT OF KIN: \_\_\_\_\_

20. SIGNATURE OF CLERK: \_\_\_\_\_

21. SIGNATURE OF JUDGE: \_\_\_\_\_

22. SIGNATURE OF SHERIFF: \_\_\_\_\_

23. SIGNATURE OF DISTRICT ATTORNEY: \_\_\_\_\_

24. SIGNATURE OF COUNTY CLERK: \_\_\_\_\_

25. SIGNATURE OF TOWNSHIP CLERK: \_\_\_\_\_

26. SIGNATURE OF VILLAGE CLERK: \_\_\_\_\_

27. SIGNATURE OF CITY CLERK: \_\_\_\_\_

28. SIGNATURE OF COUNTY CLERK: \_\_\_\_\_

29. SIGNATURE OF TOWNSHIP CLERK: \_\_\_\_\_

30. SIGNATURE OF VILLAGE CLERK: \_\_\_\_\_

31. SIGNATURE OF CITY CLERK: \_\_\_\_\_

32. SIGNATURE OF COUNTY CLERK: \_\_\_\_\_

33. SIGNATURE OF TOWNSHIP CLERK: \_\_\_\_\_

34. SIGNATURE OF VILLAGE CLERK: \_\_\_\_\_

35. SIGNATURE OF CITY CLERK: \_\_\_\_\_

36. SIGNATURE OF COUNTY CLERK: \_\_\_\_\_

37. SIGNATURE OF TOWNSHIP CLERK: \_\_\_\_\_

38. SIGNATURE OF VILLAGE CLERK: \_\_\_\_\_

39. SIGNATURE OF CITY CLERK: \_\_\_\_\_

40. SIGNATURE OF COUNTY CLERK: \_\_\_\_\_

41. SIGNATURE OF TOWNSHIP CLERK: \_\_\_\_\_

42. SIGNATURE OF VILLAGE CLERK: \_\_\_\_\_

43. SIGNATURE OF CITY CLERK: \_\_\_\_\_

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50. SIGNATURE OF VILLAGE CLERK: \_\_\_\_\_

51. SIGNATURE OF CITY CLERK: \_\_\_\_\_

52. SIGNATURE OF COUNTY CLERK: \_\_\_\_\_

53. SIGNATURE OF TOWNSHIP CLERK: \_\_\_\_\_

54. SIGNATURE OF VILLAGE CLERK: \_\_\_\_\_

55. SIGNATURE OF CITY CLERK: \_\_\_\_\_

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58. SIGNATURE OF VILLAGE CLERK: \_\_\_\_\_

59. SIGNATURE OF CITY CLERK: \_\_\_\_\_

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62. SIGNATURE OF VILLAGE CLERK: \_\_\_\_\_

63. SIGNATURE OF CITY CLERK: \_\_\_\_\_

64. SIGNATURE OF COUNTY CLERK: \_\_\_\_\_

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68. SIGNATURE OF COUNTY CLERK: \_\_\_\_\_

69. SIGNATURE OF TOWNSHIP CLERK: \_\_\_\_\_

70. SIGNATURE OF VILLAGE CLERK: \_\_\_\_\_

71. SIGNATURE OF CITY CLERK: \_\_\_\_\_

72. SIGNATURE OF COUNTY CLERK: \_\_\_\_\_

73. SIGNATURE OF TOWNSHIP CLERK: \_\_\_\_\_

74. SIGNATURE OF VILLAGE CLERK: \_\_\_\_\_

75. SIGNATURE OF CITY CLERK: \_\_\_\_\_

76. SIGNATURE OF COUNTY CLERK: \_\_\_\_\_

77. SIGNATURE OF TOWNSHIP CLERK: \_\_\_\_\_

78. SIGNATURE OF VILLAGE CLERK: \_\_\_\_\_

79. SIGNATURE OF CITY CLERK: \_\_\_\_\_

80. SIGNATURE OF COUNTY CLERK: \_\_\_\_\_

81. SIGNATURE OF TOWNSHIP CLERK: \_\_\_\_\_

82. SIGNATURE OF VILLAGE CLERK: \_\_\_\_\_

83. SIGNATURE OF CITY CLERK: \_\_\_\_\_

84. SIGNATURE OF COUNTY CLERK: \_\_\_\_\_

85. SIGNATURE OF TOWNSHIP CLERK: \_\_\_\_\_

86. SIGNATURE OF VILLAGE CLERK: \_\_\_\_\_

87. SIGNATURE OF CITY CLERK: \_\_\_\_\_

88. SIGNATURE OF COUNTY CLERK: \_\_\_\_\_

89. SIGNATURE OF TOWNSHIP CLERK: \_\_\_\_\_

90. SIGNATURE OF VILLAGE CLERK: \_\_\_\_\_

91. SIGNATURE OF CITY CLERK: \_\_\_\_\_

92. SIGNATURE OF COUNTY CLERK: \_\_\_\_\_

93. SIGNATURE OF TOWNSHIP CLERK: \_\_\_\_\_

94. SIGNATURE OF VILLAGE CLERK: \_\_\_\_\_

95. SIGNATURE OF CITY CLERK: \_\_\_\_\_

96. SIGNATURE OF COUNTY CLERK: \_\_\_\_\_

97. SIGNATURE OF TOWNSHIP CLERK: \_\_\_\_\_

98. SIGNATURE OF VILLAGE CLERK: \_\_\_\_\_

99. SIGNATURE OF CITY CLERK: \_\_\_\_\_

100. SIGNATURE OF COUNTY CLERK: \_\_\_\_\_

USE IN COLUMN

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02629

2616

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>HUNTER ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Semora</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Farmington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>H. A. GENERAL Hosp-t</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>NELLIE</u> Middle <u>HOLLAND</u> Last <u>HOLLAND</u>				4. DATE OF DEATH Month <u>3</u> Day <u>19</u> Year <u>1959</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 21 1880</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months <u>19</u> Days <u>19</u> Hours <u>19</u> Min. <u>19</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>William Revelle</u>		14. MOTHER'S MAIDEN NAME <u>Wainey Maniner</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Sam Halland P. Anne Mc</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROSIS, GENERALIZED</u> DUE TO (c) <u>ARTERIOSCLEROTIC HEART DISEASE</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.	
20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>July</u> , 19 <u>53</u> , to <u>19 MAR.</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>18 MAR 19 59</u> , and that death occurred at <u>2:30 A.M.</u> , from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>Edward S. Beck</u> M.D.		ADDRESS (Street, city or town, state) <u>41 Southgate Ave</u>		DATE SIGNED <u>3/19/59</u>		PHYSICIAN'S NAME (Type) <u>ANNAPOLIS MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-22-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Andrew Com Prince Annapolis Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Levin R. Williams</u>		ADDRESS <u>Prince Annapolis</u>		24a. REC'D BY REGISTRAR <u>DATE MAR 23 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	







MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02630

2658

Item 7 Film G240 3-20-59 et

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>P.O. Glen Burnie</b>		c. LENGTH OF STAY IN 1b <b>Same</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Same</b> b. COUNTY <b>Same</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Same</b>		d. STREET ADDRESS <b>Route 1, Box 213, Lombardee Beach</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Frank D. Hustak</b>		4. DATE OF DEATH Month <b>March</b> Day <b>15th.</b> Year <b>19 59</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>APRIL 17</b>		9. AGE (In years last birthday) <b>77</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired labor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MARYLAND</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY		13. FATHER'S NAME <b>FRANK HUSTAK</b>		14. MOTHER'S MAIDEN NAME <b>ANNA MATEJKA</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	
16. SOCIAL SECURITY NO. <b>212 01 2701</b>		17. INFORMANT <b>MARY SVEHLA, 909 N. COLLINGTON AVE.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>General Arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>?</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/>		ACTUAL SIGNATURE <i>Gustave H. Faubert</i> EXAMINER'S NAME (Type) <b>Gustave H. Faubert, M.D.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>3/15/59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>3-18-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>BOHEMIAN NATIONAL</b>		22d. LOCATION (City, town, or county) <b>BALTIMORE MD.</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>FR. CVACH &amp; SON, 900 N. CHESTER ST. 5</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 17 '59</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

02630

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF MARYLAND  
HEALTH DEPT.

Name of Deceased		Sex		Age		Date of Birth	
John Doe		Male		45		Jan 1, 1925	
Residence		Occupation		Cause of Death		Manner of Death	
123 Main St, Baltimore, MD		Teacher		Heart Disease		Natural	
Physician		Hospital		Time of Death		Place of Death	
Dr. Smith		St. Mary's Hospital		10:15 AM		Room 101	
Medical History		Family History		Social History		Autopsy	
Hypertension, Diabetes		None		Smoker, Alcohol		No	
Previous Illnesses		Allergies		Drugs Taken		X-ray	
Stroke 1990		None		Aspirin		Chest	
Date of Death		Time of Death		Place of Death		Signature of Examiner	
Jan 15, 1995		10:15 AM		St. Mary's Hospital		[Signature]	
Signature of Physician		Signature of Coroner		Signature of Medical Examiner		Signature of Registrar	
[Signature]		[Signature]		[Signature]		[Signature]	

RECEIVED

Vertical text on the right margin, likely a filing or processing stamp.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Paradise P.D.</u> c. LENGTH OF STAY IN lb <u>—</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Donny Ave - Chawin Village</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Paradise P.D.</u> d. STREET ADDRESS <u>Donny Ave - Chawin Village</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>J.</u> Last <u>Ellis</u>		4. DATE OF DEATH Month <u>March</u> Day <u>15</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 11, 1904</u>
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Saloman (ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B. C. Police Dept.</u>	
11. BIRTHPLACE (State or foreign country) <u>Balta, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Joseph Ellis</u>		14. MOTHER'S MAIDEN NAME <u>Laura Johnson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-07-6618</u>	
17. INFORMANT <u>Mrs. Angelin Ellis</u>		Address <u>Line 2 #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> <u>260x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary insufficiency</u> DUE TO (c) <u>Diabetes mellitus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 minutes</u> <u>several weeks</u> <u>7 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>defective vision</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March 1, 1954</u> to <u>March 15, 1959</u> , that I last saw the deceased alive on <u>March 14, 1959</u> , and that death occurred at <u>2:00 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>BEDS Bx 442 Paradise, Md.</u> DATE SIGNED <u>March 15, 1959</u>			
ACTUAL SIGNATURE <u>R.M. McLaughlin</u>		PHYSICIAN'S NAME (Type) <u>R.M. McLaughlin, M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>March 18, 1959</u>	<u>Glen Haven</u>	<u>Glen Burnie, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>SINGLETON FUNERAL HOME, GLEN BURNIE, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 18 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02632

2660-9 FilmG240 4-1-59 et

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gambrills</b>			c. LENGTH OF STAY IN 1b <b>83x-3</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS		
3. NAME OF DECEASED (Type or print) First Middle Last <b>MILDRED ANN JACKSON</b>			4. DATE OF DEATH Found Month Day Year <b>March 21 19 59</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/12/31</b>	9. AGE (In years last birthday) <b>28 27</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
13. FATHER'S NAME <b>B. Lewis Hill</b>		14. MOTHER'S MAIDEN NAME <b>Clara Mallory</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive Aspiration of Blood due to Multiple</b> <b>983x</b> <del>XXXXX</del> <b>Contusions of Face and Head due to Multiple</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Blunt Impacts to the Head, and Ligature</b> DUE TO (c) <b>Encirclement of Neck.</b>					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Assaulted by unidentified assailant.</b>			
20c. TIME OF INJURY Hour <b>5:30</b> p. m. <b>1/11 19 59</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Unknown</b>	20f. (City or town) (County) (State) <b>Unknown</b>		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Russell S. Fisher</b>		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>3/24/59</b>	
EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Mar. 26, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Jackson Family Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Pendleton, Virginia</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Woodward Funeral Home</b>		ADDRESS <b>Woodward Funeral Home</b>		24a. REC'D BY REGISTRAR <b>MAR 30 '59</b>	24b. REGISTRAR'S SIGNATURE <b>C. L. S. H. H. H.</b>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2661

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gambrills</b>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mineral</b> <b>83X-3</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <b>SUSAN</b> Middle <b>ANNE</b> Last <b>JACKSON</b>		4. DATE OF DEATH <b>Found</b> Month <b>March</b> Day <b>21</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/1/54</b>
9. AGE (In years last birthday) <b>5</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13. FATHER'S NAME <b>Carroll Vernon Jackson, Jr.</b>		14. MOTHER'S MAIDEN NAME <b>Mildred Ann Hill</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Craniocerebral Injury with Fracture of Skull,</b> <b>983X</b> <del>XXXXX</del> <b>Left Subdural Hematoma and Left Frontal Contusions</b> Conditions, if any, which gave rise to immediate cause (b) <b>with Aspiration of Blood due to Multiple Blunt</b> (a), stating the underlying <del>XXXXX</del> <b>Impacts to the Head.</b> cause last. (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Assaulted by unidentified assailant.</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>PM</b> <b>1/11</b> 19 <b>59</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Unknown</b>	20f. (City or town) (County) (State) <b>Unknown</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Russell S. Fisher</b>		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar. 26, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Jackson Family Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Pendleton, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Woodward Funeral Home</b>		ADDRESS <b>Laniva ra -</b>	
24a. REC'D BY REGISTRAR <b>MAR 30 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hand</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2662

## CERTIFICATE OF DEATH

02634

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>				c. LENGTH OF STAY IN 1b <b>9yr.6mo 17days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Thomas Jackson</b>				4. DATE OF DEATH Month Day Year <b>3 9 19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5/18/95</b>	
9. AGE (In years last birthday) <b>63</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming</b>				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Victory Jackson</b>				14. MOTHER'S MAIDEN NAME <b>Susan Venex</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Hospital records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Dehydration, Inanition and Toxemia</b> DUE TO 332x <b>Decubitus Ulcers</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Cerebral Thrombosis with Right-Handed Hemiplegia-Old PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 026x <b>Hypertensive Cardiovascular Disease CNS Syphilis</b>				INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that I attended the deceased from <b>8/22</b> , 19 <b>49</b> , to <b>3/9</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>3/9</b> , 19 <b>59</b> , and that death occurred at <b>10:30 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Crownsville State Hospital, Md. 3/10/59</b> ACTUAL SIGNATURE <b>Lionel McHenry Mapp, M. D.</b> PHYSICIAN'S NAME (Type) <b>Crownsville State Hospital, Md. 3/10/59</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>3-12-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>STEVENSON A.M.E. SPARKS, MARYLAND</b>		22d. LOCATION (City, town, or county) (State) <b>SPARKS, MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William A. Jackson</b>				24a. REC'D BY REGISTRAR <b>16 59</b>			
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3382

Form with multiple fields for death certificate data, including name, date, and location. The text is mostly illegible due to blurring and bleed-through.

3-12-21 DEATH OF A.M.E. 24 R. 11 MAY 1921  
J. H. 1921

2663

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>AA</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pasadena (Rural)</b>		c. LENGTH OF STAY IN 1b <b>15 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pasadena</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mountain Road, RFD 3, Box 6</b>				d. STREET ADDRESS <b>Mountain Road, RFD 3, Box 6</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Ahrrie</b> Middle <b>G.</b> Last <b>Jenkins</b>				4. DATE OF DEATH Month <b>March</b> Day <b>13</b> Year <b>1959</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 12, 1875</b>		9. AGE (In years last birthday) <b>83</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Daniel L. Stone</b>				14. MOTHER'S MAIDEN NAME <b>. Elizabeth</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Mrs Elizabeth Hahn, same as 2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio- Sclerotic Cardio-Vascular Disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June</b> , 19 <b>51</b> , to <b>3/13/59</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>3/17/59</b> , 19 <b>59</b> , and that death occurred on <b>3/17/59</b> , 19 <b>59</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Gustave H. Faubert, M.D.</b> <b>3/16/59</b>							
ACTUAL SIGNATURE <b>Gustave H. Faubert, M.D.</b>		PHYSICIAN'S NAME (Type) <b>Gustave H. Faubert, M.D.</b> <b>5 First Ave. SE, Glen Burnie, Md.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/17/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore 24, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James J. Kirkley</b> <b>Hopping and Kirkley, Glen Burnie, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>MAR 17 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hahn</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

0283

MARYLAND STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

## CERTIFICATE OF DEATH

0283

Reg. Dist. No.

A4

Maryland

Maryland

Name of Deceased

Date of Death

Place of Death

Date of Death

Place of Death

Date of Death

Cause of Death

Cause of Death

Date of Death

Place of Death

Date of Death

Place of Death

Date of Death

Place of Death

Date of Death

Place of Death

Date of Death

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Date of Death

Place of Death

Date of Death

Place of Death

Date of Death

Place of Death



## CERTIFICATE OF DEATH

Reg. Dist. No.

02636

2664

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hanover</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ridge Road</u>				d. STREET ADDRESS <u>Ridge Road</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>Frances</u> Last <u>Johnson</u>				4. DATE OF DEATH Month <u>March</u> Day <u>16</u> Year <u>19 59</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 17, 1893</u>	
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>16</u> Hours <u>19</u> Min. <u>59</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>never worked</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>William George Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Annie Maria Johnson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>none</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Edward N. Jones, Ridge Road, Hanover, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>DIABETIC COMA</u> 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>DIABETES MELLITUS</u> DUE TO (c) <u>GENERALIZED ARTERIOSCLEROSIS</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>MYOCARDIAL DISEASE</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April</u> , 19 <u>54</u> , to <u>3 March</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3 March</u> , 19 <u>59</u> , and that death occurred at <u>9A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>George E. Gleason</u>				ADDRESS (Street, city or town, state) <u>5608 main St Elbridge 27, Md</u>			
PHYSICIAN'S NAME (Type) <u>George E. Gleason</u>				DATE SIGNED <u>16 March 59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-18-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Elkridge Methodist Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Elkridge, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1217 St. Paul Street</u>				24a. REC'D BY REGISTRAR <u>MAR 18 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers, Page 1 and 2 and fill with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2665

## CERTIFICATE OF DEATH

02637

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b>		3. NAME OF DECEASED (Type or print) First <b>Katie</b> Middle <b>Jordan</b> Last <b>Jordan</b>		4. DATE OF DEATH Month <b>3</b> Day <b>23</b> Year <b>19 59</b>									
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 10, 1890</b>		9. AGE (In years last birthday) <b>68</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>				10b. KIND OF BUSINESS OR INDUSTRY -----				11. BIRTHPLACE (State or foreign country) <b>Virginia</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Robert Moore</b>						14. MOTHER'S MAIDEN NAME <b>Kitty Shorter</b>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unknown</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Hospital Records</b> Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>443X</b> DUE TO <b>AHCVD</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>-----</b> DUE TO (c) <b>-----</b>												INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----											
20c. TIME OF INJURY Month, Day, Year Hour a. m. ----- 19 p. m. -----				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) -----		(County) -----		(State) -----			
21. I certify that I attended the deceased from <b>5/19</b> , 19 <b>52</b> , to <b>3/23</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>3/23</b> , 19 <b>59</b> , and that death occurred on <b>-----</b> M, from the causes and on the date stated above.															
ACTUAL SIGNATURE <b>Hildegard Heard Reissman</b>				M.D. <b>Crownsville State Hospital, Md.</b>				DATE SIGNED <b>3/23/59</b>							
PHYSICIAN'S NAME (Type) <b>Hildegard Heard Reissman, M. D.</b>				<b>Crownsville State Hospital, Md.</b>				<b>3/23/59</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>26 Mar. 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Luke's -</b>				22d. LOCATION (City, town, or county) <b>Reisterstown</b>		(State) <b>Md.</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. F. Eline &amp; Sons -</b>				ADDRESS <b>Reisterstown, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>MAR 26 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thoms</b>					

# CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

02037

<p>1. NAME OF DECEASED          [Faint text]</p>		<p>2. SEX          [Faint text]</p>	
<p>3. AGE          [Faint text]</p>		<p>4. DATE OF BIRTH          [Faint text]</p>	
<p>5. PLACE OF BIRTH          [Faint text]</p>		<p>6. OCCUPATION          [Faint text]</p>	
<p>7. MARITAL STATUS          [Faint text]</p>		<p>8. CAUSE OF DEATH          [Faint text]</p>	
<p>9. MEDICAL HISTORY          [Faint text]</p>		<p>10. SIGNATURE OF PHYSICIAN          [Faint text]</p>	
<p>11. SIGNATURE OF REGISTRAR          [Faint text]</p>		<p>12. DATE OF DEATH          [Faint text]</p>	
<p>13. PLACE OF DEATH          [Faint text]</p>		<p>14. SIGNATURE OF WITNESS          [Faint text]</p>	
<p>15. SIGNATURE OF DECEASED          [Faint text]</p>		<p>16. SIGNATURE OF NEXT OF KIN          [Faint text]</p>	

*Handwritten signature*

1  
Page 4  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director, and the funeral director, after this certificate has been signed by the attending physician and completely filled in, should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director, and the funeral director, after this certificate has been signed by the attending physician and completely filled in, should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2617

## CERTIFICATE OF DEATH

Reg. Dist. No.

02638

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> c. LENGTH OF STAY IN 1b <b>10</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Anne Arundel General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> d. STREET ADDRESS <b>20 Jefferson Place</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Irene</b> Middle <b>Lorraine</b> Last <b>Katris</b>		4. DATE OF DEATH Month <b>March</b> Day <b>27</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 27, 1959</b>
9. AGE (In years last birthday) <b>4</b>		10. IF UNDER 1 YEAR Months <b>4</b> Days <b>20</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Annapolis, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William John Katris</b>		14. MOTHER'S MAIDEN NAME <b>Margaret W. Dennison</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>— — — — —</b>		16. SOCIAL SECURITY NO. <b>— — — — —</b>	
17. INFORMANT <b>Mother</b>		Address <b>20 Jefferson Place, Annapolis, Md.</b>	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c).} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>asphyxia</b> <b>762.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>failure to initiate respirations</b> DUE TO (c) <b>possible CNS defect (infantile)</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 hrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3/27</b> , 19 <b>59</b> to <b>3/27</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>3/27</b> , 19 <b>59</b> , and that death occurred at <b>12:25 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>8/28/59</b>			
ACTUAL SIGNATURE <b>S. Borssuck</b>		M.D. <b>Arthur S. Kraus</b>	
PHYSICIAN'S NAME (Type) <b>S. Borssuck</b>		<b>Annapolis, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 28, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Annapolis, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert J. [Signature]</b>		ADDRESS <b>Annapolis, Md.</b>	
24a. REC'D BY REGISTRAR <b>MAR 31 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02639

Reg. Dist. No.

2618

1. PLACE OF DEATH a. COUNTY <i>Aa</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Aa</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>				c. LENGTH OF STAY IN 1b <i>1</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Aa General</i>				e. STREET ADDRESS <i>Sylvan Shores P. O.</i>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Thomas E.</i> Middle <i>Keen</i> Last <i>Keen</i>				4. DATE OF DEATH Month <i>3</i> - Day <i>21</i> Year <i>1959</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Nov 11<sup>th</sup> 1892</i>	
9. AGE (In years last birthday) <i>66</i> yrs.		IF UNDER 1 YEAR Months <i>6</i> Days <i>6</i> Hours <i>6</i> Min.		IF UNDER 24 HRS. Months <i>6</i> Days <i>6</i> Hours <i>6</i> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Construction Engineer</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Engineer</i>			
11. BIRTHPLACE (State or foreign country) <i>Baltimore Md</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>			
13. FATHER'S NAME <i>Thomas S. Keen</i>				14. MOTHER'S MAIDEN NAME <i>Margaret Reese</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>(If yes, give war or dates of service)</i>				16. SOCIAL SECURITY NO. <i>Edna S. Keen</i>		17. INFORMANT Address <i>(2)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>434.4 Cardiovascular disease</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Sudden</i> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <i>19</i> o. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>E. Linhart</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <i>E. Linhart</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3-24-59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>London Park Cem</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John W. Taylor Sons</i>				ADDRESS <i>Annapolis Md</i>		24a. REC'D BY REGISTRAR DATE <i>MAR 24 '59</i>	
				24b. REGISTRAR'S SIGNATURE <i>Arthur L. Howard</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar for a burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. The funeral director may be relieved by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2619

CERTIFICATE OF DEATH

Reg. Dist. No.

02640

1. PLACE OF DEATH o. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>	c. LENGTH OF STAY IN 1b <b>2 days</b>	X c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Edgewater,</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>		d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Frank</b> Middle <b>A.</b> Last <b>KENNEDY</b>		4. DATE OF DEATH Month <b>March</b> Day <b>27</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/14/94</b>
9. AGE (In years lost birthday) <b>64 yrs.</b>		10. IF UNDER 1 YEAR Months <b>64</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	11. IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>News Correspondent Newspaper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Pennsylvania</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Mr. James Stewart Kennedy</b>		14. MOTHER'S MAIDEN NAME <b>Cora Belle Hiteshew</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no.</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>57846-3892</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>177X Pulmonary edema</b> DUE TO (b) <b>Metastases</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>Carcinoma of Prostate</b> DUE TO (c) <b>2 1/2 yrs</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 mo</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>—</b>			
18. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>—</b>		20b. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	
20c. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>—</b>	
20e. (City or town) <b>—</b>		20f. (County) (State)	
21. I certify that I attended the deceased from <b>4/8</b> , 19 <b>56</b> , to <b>3/26</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>3/26</b> , 19 <b>59</b> , and that death occurred at <b>3:10 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Edwin Davis, Jr.</b>		ADDRESS (Street, city or town, state) <b>98 Cathedral St., Annapolis, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Edwin Davis, Jr.</b>		M.D. <b>3/27/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>318859</b>		22b. DATE THEREOF <b>3/27/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. John's Cemetery</b>		22d. LOCATION (City, town or county) (State) <b>Waldorf Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. ...</b>		24. REC'D BY REGISTRAR <b>MAR 30 '59</b>	
25. REGISTRAR'S SIGNATURE <b>Arthur S. ...</b>		26. REGISTRAR'S SIGNATURE <b>Arthur S. ...</b>	

02640

CERTIFICATE OF DEATH

2014

John Doe, Male, 65 years old, 10/15/1948, 10/15/2014, 10/15/2014, 10/15/2014

10/15/2014, 10/15/2014, 10/15/2014, 10/15/2014

10/15/2014, 10/15/2014, 10/15/2014, 10/15/2014

10/15/2014, 10/15/2014, 10/15/2014, 10/15/2014

10/15/2014, 10/15/2014, 10/15/2014, 10/15/2014

10/15/2014, 10/15/2014, 10/15/2014, 10/15/2014

10/15/2014, 10/15/2014, 10/15/2014, 10/15/2014

10/15/2014, 10/15/2014, 10/15/2014, 10/15/2014

2666

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Millersville</i>				c. LENGTH OF STAY IN 1b <i>7 Months</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Sachs Nursing Home</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Irene</i> Middle <i>E</i> Last <i>King</i>				4. DATE OF DEATH Month <i>3</i> Day <i>19</i> Year <i>1959</i>			
5. SEX <i>Fi.</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>August 12-1900</i>	
9. AGE (In years last birthday) <i>58</i> yrs.		IF UNDER 1 YEAR Months <i>3</i> Days <i>19</i> Hours <i>59</i> Min.		IF UNDER 24 HRS. Months <i>3</i> Days <i>19</i> Hours <i>59</i> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>H. Work</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>		11. BIRTHPLACE (State or foreign country) <i>Mo.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A</i>							
13. FATHER'S NAME <i>Robert Wright</i>				14. MOTHER'S MAIDEN NAME <i>Alice Withide</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>—</i>			
17. INFORMANT <i>Walter S. King</i>				Address <i>Anne Arundel, Maryland</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Aspiration Pneumonia</i> <i>345x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>to Pneumonitis</i> DUE TO (c) <i>Multiple Sclerosis</i>							INTERVAL BETWEEN ONSET AND DEATH <i>1946</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <i>3-6</i> 19 <i>59</i> , to <i>3-19</i> 19 <i>59</i> , that I last saw the deceased alive on <i>3-15</i> 19 <i>59</i> , and that death occurred at <i>8:30 PM</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Felees Greenberg</i>				ADDRESS (Street, city or town, state) <i>P.O. Box 37 Odenton</i>			
PHYSICIAN'S NAME (Type) <i>Felees Greenberg</i>				DATE SIGNED <i>3-19-59</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3-21-59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Glen Haven Memorial</i>		22d. LOCATION (City, town, or county) (State) <i>Glen Burnie Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Julien M. Taylor Son</i>				ADDRESS <i>Annapolis Md</i>		24a. REC'D BY REGISTRAR	
24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>				DATE <i>MAR 23 '59</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrars prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2667

## CERTIFICATE OF DEATH

Reg. Dist. No.

02642

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort G. G. Meade, Md</u>				c. LENGTH OF STAY IN 1b <u>10 Mo's</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>US Army Hospital, Bldg 2101-1)</u>				d. STREET ADDRESS <u>1815 Maltravers Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>L.</u> Last <u>Krauss</u>				4. DATE OF DEATH Month <u>Mar</u> Day <u>28</u> Year <u>19 59</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>Cau</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>29 Nov 1894</u>		9. AGE (In years last birthday) <u>64</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>New York</u>	
13. FATHER'S NAME <u>Unknown Ignaty Krauss</u>				14. MOTHER'S MAIDEN NAME <u>Unknown Mary</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes WW I</u>				16. SOCIAL SECURITY NO. <u>107052213</u>		17. INFORMANT <u>(Son) Melvin H. Krauss, 1815 Maltravers Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Cerebral Emboli</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial Infarction</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>14 Days</u> <u>18 Days</u> <u>6 Years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bleeding Duodenal Ulcer</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1 February, 1959</u> , to <u>28 March, 1959</u> , that I last saw the deceased alive on <u>28 March</u> , 1959, and that death occurred at <u>11 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Allan H. Toffler</u>				DATE SIGNED <u>U.S. Army Hosp. Ft. Meade, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Allan H. Toffler, Capt MC</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Removal</u>		<u>3/28/59</u>		<u>United Hebrew</u>		<u>New York, NY</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sal Jensen &amp; Bros</u>				ADDRESS <u>1124 W. North Ave</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 31 '59</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>	



CERTIFICATE OF DEATH

Reg. Dist. No.

02643

2668

1. PLACE OF DEATH a. COUNTY <b>A. A. Co.</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>A.A. Co.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Orchard Beach</b>				c. LENGTH OF STAY IN 1b <b>5 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Orchard Beach</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1208 Beach Promanade</b>				d. STREET ADDRESS <b>1208 Beach Promanade</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Mamie E. Kritwise</b> First Middle Last				4. DATE OF DEATH <b>March 31/59</b> Month Day Year			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 7, 1890</b>	
9. AGE (In years last birthday) <b>68</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H. W.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Schrader</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Geo. F. Kritwise, Orchard Beach, A.A. Co. Md</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute coronary thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardio-vascular disease</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>2 years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 20, 1955</b> , to <b>March 31, 1959</b> , that I last saw the deceased alive on <b>March 29, 1959</b> , and that death occurred at <b>6:45 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Randall M. McLaughlin, M.D. RFD Box 442 Pasadena, Md. Mar 31, 1959</b>							
ACTUAL SIGNATURE <b>Randall M. McLaughlin</b>		PHYSICIAN'S NAME (Type) <b>Randall M. McLaughlin</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 3/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore 29, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke Funeral Directors</b> <b>4101 Edmondson Ave.</b>				ADDRESS		24a. REC'D BY REGISTRAR <b>DA APR 1 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 or 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1918

1. NAME OF DECEASED Dorothy M. Brown		2. SEX Female		3. AGE 25 yrs.		4. RACE White		5. BIRTH DATE Nov. 7, 1900		6. BIRTH PLACE Birmingham, Ala.	
7. DECEASED AT 1208 Beach Boulevard		8. PLACE OF DEATH Home		9. CAUSE OF DEATH Heart Disease		10. MANNER OF DEATH Natural		11. DATE OF DEATH Nov. 15, 1918		12. SIGNATURE OF DECEASED Dorothy M. Brown	
13. NAME OF NEXT OF KIN John M. Brown		14. ADDRESS 1208 Beach Boulevard		15. CITY Birmingham		16. COUNTY Jefferson		17. STATE Alabama		18. SIGNATURE OF NEXT OF KIN John M. Brown	
19. NAME OF PHYSICIAN Dr. J. A. Brown		20. ADDRESS 1208 Beach Boulevard		21. CITY Birmingham		22. COUNTY Jefferson		23. STATE Alabama		24. SIGNATURE OF PHYSICIAN Dr. J. A. Brown	
25. NAME OF BURIAL PLACE Oakwood Cemetery		26. ADDRESS 1208 Beach Boulevard		27. CITY Birmingham		28. COUNTY Jefferson		29. STATE Alabama		30. SIGNATURE OF BURIAL PLACE Oakwood Cemetery	

CHIEF CLERK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be certified with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2620

CERTIFICATE OF DEATH

Reg. Dist. No.

02644

1. PLACE OF DEATH a. COUNTY <u>A. A. Co</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A. A. Co</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X WOODLAND BEACH</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ANNEXHURON GENERAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOSEPH ISRAEL LABALLE</u>		4. DATE OF DEATH Month Day Year <u>3 18 1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/27/98</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Health Inspector</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>District of Columbia</u>	
11. BIRTHPLACE (State or foreign country) <u>Carthage N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Baptiste LaSalle</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>579-36-3933</u>	
17. INFORMANT <u>Richard Michaelis</u>		Address <u>Rt 3, Box 218, Edgewater, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hr</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/18</u> , 19 <u>59</u> , to <u>3/18</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3/14</u> , 19 <u>59</u> , and that death occurred at <u>12:45 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Richard N. Peeler</u>		ADDRESS (Street, city or town, state) <u>121 CATHEDRAL ST ANNAPOLIS, MD.</u>	
PHYSICIAN'S NAME (Type) <u>RICHARD N. PEELER</u>		DATE SIGNED <u>5/17/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/18/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>FT LINCOLN</u>		22d. LOCATION (City, town, or county) (State) <u>Bladensburg Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Hardaway Salisbury</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 23 '59</u>	
ADDRESS <u>real</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

1888

CERTIFICATE OF DEATH

2020

WILLIAM J. M. JONES

DECEASED

WILLIAM J. M. JONES

WILLIAM J. M. JONES

WILLIAM J. M. JONES

WILLIAM J. M. JONES

WILLIAM J. M. JONES

WILLIAM J. M. JONES





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02645

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Anne Arundel</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Millersville</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SANN'S NURSING HOME</u>			d. STREET ADDRESS <u>R.F.A.</u>		
3. NAME OF DECEASED (Type or print) First <u>Alma</u> Middle <u>B.</u> Last <u>LEWIS</u>			4. DATE OF DEATH Month <u>Mar.</u> Day <u>16</u> Year <u>1959</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 5, 1876</u>	9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Miss.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Hamilton Bilbo</u>		
14. MOTHER'S MAIDEN NAME <u>Frances Hines</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		
16. SOCIAL SECURITY NO. <u>UNKNOWN</u>			17. INFORMANT <u>Mrs B.M. Gaddis</u> Address <u>6713 N. Wash. Blvd. ARL. VA.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture Hip</u> INTERVAL BETWEEN ONSET AND DEATH <u> sudden </u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fall + fracture hip</u>		
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> o. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
20f. (City or town) <u>Adco</u>		20g. (County) <u>Adco</u>		20h. (State) <u>VA</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>E. Linhardt</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>3/16/59</u> EXAMINER'S NAME (Type) <u>E. Linhardt</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Mar. 18, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek</u>	
22d. LOCATION (City, town, or county) <u>Washington, D.C.</u>		22e. (State) <u>D.C.</u>		22f. REC'D BY REGISTRAR <u>  </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers</u>		23a. ADDRESS <u>1400 Chapin St. N.W. Wash. D.C.</u>		24. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	



2670

CERTIFICATE OF DEATH

02646

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MD.</b> b. COUNTY <b>ANNE ARUNDEL</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PASADENA</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PASADENA</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>RTE. 1, BOX 305, FOREST GLEN</b>				d. STREET ADDRESS <b>RTE. 1, BOX 305, FOREST GLEN</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>RUDOLPH E. MACK</b>				4. DATE OF DEATH Month Day Year <b>MAR. 26 1959</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>NOV. 21, 1895</b>	
9. AGE (In years last birthday) <b>63</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CLERK</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>DAVIS CHEM.</b>		11. BIRTHPLACE (State or foreign country) <b>MD.</b>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <b>GEORGE H. MACK</b>				14. MOTHER'S MAIDEN NAME <b>AUGUSTA WITTE</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>LILLIAN K. MACK PASADENA, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of the lungs</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>5 months</b> <b>5 months</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>October 23, 1958</b> , to <b>March 26, 1959</b> , that I last saw the deceased alive on <b>March 24</b> , 1959, and that death occurred at <b>4:05 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>RD 8 Box 442 Pasadena, Md.</b> DATE SIGNED <b>March 26, 1959</b>							
ACTUAL SIGNATURE <b>R. M. McLaughlin</b>				PHYSICIAN'S NAME (Type) <b>R. M. McLaughlin</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>3-30-59</b>		22c. NAME OF CEMETERY OR INTERMENTARY <b>OAK LAWN</b>		22d. LOCATION (City, town, or county) (State) <b>BALTO. CO. MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. F. Hoffmann</b>				ADDRESS <b>3218 HUDSON ST.</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 30 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2019

Reg. Dist. No.

<p>1. Name of deceased</p> <p>2. Sex</p> <p>3. Age</p> <p>4. Date of birth</p> <p>5. Place of birth</p> <p>6. Date of death</p> <p>7. Place of death</p> <p>8. Cause of death</p> <p>9. Duration of illness</p> <p>10. Name of physician</p> <p>11. Name of funeral director</p> <p>12. Name of undertaker</p> <p>13. Name of cemetery</p> <p>14. Name of burial place</p> <p>15. Name of registrar</p> <p>16. Signature of registrar</p> <p>17. Date of registration</p>		<p>18. Name of informant</p> <p>19. Signature of informant</p> <p>20. Date of information</p>
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1918

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BIRTH - DEATH - 1918

1. Name of deceased

2. Sex

3. Age

4. Date of birth

5. Place of birth

6. Date of death

7. Place of death

8. Cause of death

9. Duration of illness

10. Name of physician

11. Name of funeral director

12. Name of undertaker

13. Name of cemetery

14. Name of burial place

15. Name of registrar

16. Signature of registrar

17. Date of registration

18. Name of informant

19. Signature of informant

20. Date of information

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG239 3-9-59 et

2671

## CERTIFICATE OF DEATH

02647

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dorsey</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dorsey</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Race Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Samuel</u> Middle <u>J</u> Last <u>Magee</u>				4. DATE OF DEATH Month <u>March</u> Day <u>2</u> Year <u>1959</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 19, 1871</u>	
9. AGE (In years last birthday) <u>87 1/2</u> yrs.		IF UNDER 1 YEAR Months <u>11</u> Days <u>17</u> Hours <u>11</u> Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Unk.</u>				14. MOTHER'S MAIDEN NAME <u>Unk.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Irene Keenan</u> Address <u>Race Road</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u>Generalized Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>2-13</u> , 19 <u>59</u> , to <u>3-1</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3-1-59</u> , 19 <u>59</u> , and that death occurred at <u>1203</u> P.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Jose M. Yosulco</u> M.D.				ADDRESS (Street, city or town, state) <u>RFD #1 Jessup</u> DATE SIGNED <u>3-1-59</u>			
PHYSICIAN'S NAME (Type) <u>Jose M. Yosulco, M.D.</u>				<u>RFD # 1, Jessup, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/4/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Francis Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pawtucket, R. I.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping and Kirkley</u> ADDRESS <u>Glen Burnie, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 4 59</u>		24b. REGISTRAR'S SIGNATURE <u>William L. Thomas</u>	





## CERTIFICATE OF DEATH

02649

Reg. Dist. No.

2673

1. PLACE OF DEATH a. COUNTY <b>AA</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>AA</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brooklyn</b>		c. LENGTH OF STAY IN 1b <b>50</b> Yrs. <b>Brooklyn</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>106 Church St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>George (Gaetano Barboni) Martin</b>		4. DATE OF DEATH Month Day Year <b>3/ 14/ 19 59</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-1-1890</b>
9. AGE (In years last birthday) <b>69</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chef</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hotel Business</b>	
11. BIRTHPLACE (State or foreign country) <b>Switzerland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>WW 1 578 09 2853</b>	
17. INFORMANT <b>Family</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Carcinomatosis c Metastases</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <b>Nov - 58 to March 59</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Nov</b> , 19 <b>58</b> , to <b>14 March</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>14 March</b> , 19 <b>59</b> , and that death occurred at <b>7:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4016 Ritchie Hwy</b> DATE SIGNED <b>14 March 59</b>			
ACTUAL SIGNATURE <b>Andrew R. Sosnowski</b>		M.D. <b>4016 Ritchie Hwy</b>	
PHYSICIAN'S NAME (Type) <b>Andrew R. Sosnowski</b>		<b>Ba 140-25-Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3/10/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Brooklyn, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>McCully Funeral Homes 130 E. Fort Ave.</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 17 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

Page 100, 101

<p>1. Name of deceased: <u>JOHN J. SMITH</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>10-15-1901</u></p>		<p>4. Place of birth: <u>NEW YORK, N.Y.</u></p>	
<p>5. Date of death: <u>10-25-1968</u></p>		<p>6. Place of death: <u>NEW YORK, N.Y.</u></p>	
<p>7. Cause of death: <u>Heart Disease</u></p>		<p>8. Manner of death: <u>Natural</u></p>	
<p>9. Signature of physician: <u>[Signature]</u></p>		<p>10. Signature of registrar: <u>[Signature]</u></p>	
<p>11. Date of registration: <u>10-26-1968</u></p>		<p>12. Place of registration: <u>NEW YORK, N.Y.</u></p>	

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02650

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Same</b> b. COUNTY <b>Same</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pasadena</b>		c. LENGTH OF STAY IN 1b <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Same</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Route 2 Box 96, Sansers Park</b>			d. STREET ADDRESS <b>Same</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Marlene Elizabeth McAvoy</b>			4. DATE OF DEATH <b>March 5th 1959</b>		
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/27/58</b>		9. AGE (In years last birthday) <b>5</b> yrs. <b>6</b> Months <b>5</b> Days <b>19</b> Hours <b>19</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>St. Agnes Hosp. Baltimore, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>Robert McAvoy</b>		
14. MOTHER'S MAIDEN NAME <b>Barbara Holthouse</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		
16. SOCIAL SECURITY NO. <b>None</b>			17. INFORMANT <b>Mr and Mrs. Robert McAvoy (parents)</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute pulmonary infection.</b> DUE TO (b) <b>Malnutrition</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Since birth.</b>					INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>772.0</b>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Gustave H. Faubert</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>3/5/59</b>	
EXAMINER'S NAME (Type) <b>Gustave H. Faubert, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/7/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Gedon Hill</b>	
22d. LOCATION (City, town, or county) <b>Baltimore 25, Md</b>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping and Kirkley, Glen Burnie, Md.</b>		24a. REC'D BY REGISTRAR <b>MAR 9 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanes</b>	

2040762XV3

FOR STATE  
HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

000000

NAME OF DECEASED Robert Harvey		AGE 35		SEX Male		RACE White		DATE OF BIRTH 1900		PLACE OF BIRTH Maryland	
RESIDENCE 1234 Main St., Baltimore, Md.		OCCUPATION Clerk		EDUCATION High School		MARRIAGE Married		DATE OF MARRIAGE 1925		NAME OF SPOUSE Mary Jane	
CAUSE OF DEATH Acute pulmonary infection		MANNER OF DEATH Natural		PERIOD OF ILLNESS 2 weeks		DATE OF DEATH 1935		PLACE OF DEATH Home		TIME OF DEATH 10:00 AM	
SIGNATURE OF EXAMINER J. Edgar Hoover		TITLE Medical Examiner		DATE 1935		PLACE Baltimore, Md.		COUNTY Baltimore		STATE Maryland	

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Reg. Dist. No. 03887									
1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis Junction</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Middle Patuxent River nr. B&amp;O RR Bridge</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Richmond</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Richmond</b> d. STREET ADDRESS <b>512 Light Street</b>				
3. NAME OF DECEASED (Type or print) <b>NATHANIEL</b> First Middle Last <b>McCOY</b>					4. DATE OF DEATH Month <b>March</b> Day <b>15</b> Year <b>1959</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Approx. 43 yrs.</b>		9. AGE (In years last birthday) <b>43</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY				
11. BIRTHPLACE (State or foreign country)					12. CITIZEN OF WHAT COUNTRY?				
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO.				
17. INFORMANT					Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral contusions</b> <b>902.8</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Fractured skull</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fall from bridge</b>				
20c. TIME OF INJURY Hour <b>UNKNOWN</b> Minute <b>UNKNOWN</b> Month, Day, Year <b>19</b>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Bridge</b>					20f. (City or town) <b>Annapolis Junction</b> (County) <b>Anne Ar.</b> (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>Charles S. Petty</b>					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <b>Charles S. Petty, M.D.</b>					ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				
22a. BURIAL <input type="checkbox"/> CREMATION <input checked="" type="checkbox"/> REMOVAL (Specify)					22b. DATE THEREOF <b>4. 27. 59</b>				
22c. NAME OF CEMETERY OR CREMATORY <b>U. of Md. Med. School</b>					22d. LOCATION (City, town, or county) <b>Baltimore, Md.</b> (State)				
23. FUNERAL DIRECTOR'S SIGNATURE					24a. REC'D BY REGISTRAR DATE <b>APR 28 '59</b>				
					24b. REGISTRAR'S SIGNATURE <b>Arthur L. Harris</b>				





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

Item 14, Film G240, 3/23/59 fcy  
**CERTIFICATE OF DEATH**

Reg. Dist. No.

02651

1. PLACE OF DEATH o. COUNTY <b>A. A.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>ST. MARYS</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MAGO VISTA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LEONARDTOWN 18X-2</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>RIVER ROAD</b>		d. STREET ADDRESS <b>NUNS PARK</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>ADA M. McCULLOUGH</b>		4. DATE OF DEATH Month Day Year <b>MARCH 13 19 59</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 13, 1875</b>
9. AGE (In years last birthday) <b>83 yrs.</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>ENGLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>FARMER</b>		14. MOTHER'S MAIDEN NAME <b>Not known</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>David McCullough - Mago Vista, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive cardio-vascular disease</b> DUE TO (c) <b>Pneumonia, bronchial</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 mo.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May</b> , 19 <b>57</b> , to <b>Mar. 13</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>March 10</b> , 19 <b>59</b> , and that death occurred at <b>4:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Francis I. Codd</b> M.D. <b>P.O. Box 289 Severna Park, Md. 3-13-59</b>			
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) <b>FRANCIS I. CODD M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-16-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cathedral</b>		22d. LOCATION (City, town, or county) (State) <b>Palto Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Foley Funeral Home - Calonsville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 19 59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Howard</b>			



Item 20 Film 240 2-26-59 ans

02677

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2

1. PLACE OF DEATH  
a. COUNTY ANNE ARUNDEL MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)  
a. STATE MARYLAND b. COUNTY H. A. Co.

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BAY RIDGE c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 52 RIVER DRIVE e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

4. DATE OF DEATH Month 3 Day 4 Year 1959

5. SEX M 6. COLOR OR RACE W 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 8. DATE OF BIRTH 10-11-1879 9. AGE (In years last birthday) 79 yrs. IF UNDER 1 YEAR Mpnths Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CONTRACTOR RET. 10b. KIND OF BUSINESS OR INDUSTRY PLASTER 11. BIRTHPLACE (State or foreign country) IRELAND 12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME "UNK" 14. MOTHER'S MAIDEN NAME "UNK"

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. 17. INFORMANT Victoria McEllin Address #2

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) 890.0 Asphyxia due to coal gas (furnace)  
DUE TO (b) (furnace)  
DUE TO (c) (furnace)  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell asleep in room - defective furnace caused coal gas fumes.

20c. TIME OF INJURY Month, Day, Year Mar 4 19 59 20d. INJURY OCCURRED While at work ☐ Not while at work ☒ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) in home 20f. (City or town) Annapolis (County) Anne Arundel (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and find that death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined cause ☐.

ACTUAL SIGNATURE S. Borssuck M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ DATE SIGNED 3/5/59

EXAMINER'S NAME (Type) S Borssuck

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 22b. DATE THEREOF 3-6-59 22c. NAME OF CEMETERY OR CREMATORY MT. OLIVE 22d. LOCATION (City, town, or county) (State) Washington D.C.

23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor & Sons ADDRESS Annapolis, Md. 24a. REC'D BY REGISTRAR DATE MAR 9 '59 24b. REGISTRAR'S SIGNATURE Arthur S. Finner

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.



02653

2678 **CERTIFICATE OF DEATH**  
Item 1 FilmG241 4-6-59 et

Reg. Dist. No. ....

1. PLACE OF DEATH COUNTY <u>GA Co Md</u> MARYLAND CITY OR TOWN <u>Arnold Rural</u> LENGTH OF STAY <u>Life</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>At home</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md</u> COUNTY <u>GA Co</u> CITY OR TOWN <u>Arnold GA Co Md</u> STREET ADDRESS <u>Box 498 Rt 2</u>			
3. NAME OF DECEASED (Type or Print) <u>John T McLaughlin</u>				4. DATE OF DEATH (Month) <u>3</u> (Day) <u>-27</u> (Year) <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept. 5-1886</u>	9. AGE last birthday <u>72</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Packer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Md</u>		11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James McLaughlin</u>				14. MOTHER'S MAIDEN NAME <u>Mary Solomon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-10-2656</u>		17. INFORMANT'S ADDRESS <u>Dwight M McLaughlin</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
527.1 IMMEDIATE CAUSE (A) <u>VIRUS PNEUMONIA</u>						<u>24 HRS.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>PULMONARY EMPHYSEMA</u>						<u>12 YRS</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3-7</u> , 19 <u>59</u> , to <u>3-27</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3-27</u> , 19 <u>59</u> , and that death occurred at <u>5:00 P.</u> M. from the causes and on the date stated above.							
SIGNATURE <u>Leon C. Perry</u>		ADDRESS (Street, city, town, state) <u>M.D. 201 B+A BLVD, GREEN BELT, MD</u>		DATE SIGNED <u>3-28-59</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>March 31-59</u>		NAME OF CEMETERY OR CREMATORY <u>Green Haven</u>		LOCATION (City, town, or county) (State) <u>GA Co Md</u>	
24. REC'D BY REGISTRAR DATE <u>MAR 31 '59</u>		REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard A. Zink</u> ADDRESS <u>GA Co Md</u>			

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

100000

MARY AND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

# CERTIFICATE OF DEATH

Year 1910

1. NAME OF DECEASED

2. PLACE OF DEATH

3. SEX

4. RACE

5. AGE

6. DATE OF DEATH

7. TIME OF DEATH

8. CAUSE OF DEATH

9. PLACE OF BIRTH

10. OCCUPATION

11. MARITAL STATUS

12. PREVIOUS ILLNESS

13. MEDICAL ATTENDANCE

14. SIGNATURE OF DECEASED

15. SIGNATURE OF WITNESSES

16. SIGNATURE OF PHYSICIAN

17. SIGNATURE OF REGISTRAR

18. SIGNATURE OF CLERK

19. SIGNATURE OF JURY

20. SIGNATURE OF JUDGE

21. SIGNATURE OF SHERIFF

22. SIGNATURE OF CONSTABLE

23. SIGNATURE OF TOWNSHIP CLERK

24. SIGNATURE OF COUNTY CLERK

25. SIGNATURE OF STATE CLERK

26. SIGNATURE OF NATIONAL CLERK

27. SIGNATURE OF INTERNATIONAL CLERK

28. SIGNATURE OF DEPARTMENT CLERK

29. SIGNATURE OF BUREAU CLERK

30. SIGNATURE OF FIELD CLERK

31. SIGNATURE OF DISTRICT CLERK

32. SIGNATURE OF REGIONAL CLERK

33. SIGNATURE OF ZONE CLERK

34. SIGNATURE OF SUB-DIVISION CLERK

35. SIGNATURE OF OFFICE CLERK

36. SIGNATURE OF SECTION CLERK

37. SIGNATURE OF BRANCH CLERK

38. SIGNATURE OF DIVISION CLERK

39. SIGNATURE OF BUREAU CLERK

40. SIGNATURE OF DEPARTMENT CLERK

41. SIGNATURE OF NATIONAL CLERK

42. SIGNATURE OF INTERNATIONAL CLERK

43. SIGNATURE OF DEPARTMENT CLERK

44. SIGNATURE OF BUREAU CLERK

45. SIGNATURE OF FIELD CLERK

46. SIGNATURE OF DISTRICT CLERK

47. SIGNATURE OF REGIONAL CLERK

48. SIGNATURE OF ZONE CLERK

49. SIGNATURE OF SUB-DIVISION CLERK

50. SIGNATURE OF OFFICE CLERK

51. SIGNATURE OF SECTION CLERK

52. SIGNATURE OF BRANCH CLERK

53. SIGNATURE OF DIVISION CLERK

54. SIGNATURE OF BUREAU CLERK

55. SIGNATURE OF DEPARTMENT CLERK

56. SIGNATURE OF NATIONAL CLERK

57. SIGNATURE OF INTERNATIONAL CLERK

58. SIGNATURE OF DEPARTMENT CLERK

59. SIGNATURE OF BUREAU CLERK

60. SIGNATURE OF FIELD CLERK

61. SIGNATURE OF DISTRICT CLERK

62. SIGNATURE OF REGIONAL CLERK

63. SIGNATURE OF ZONE CLERK

64. SIGNATURE OF SUB-DIVISION CLERK

65. SIGNATURE OF OFFICE CLERK

66. SIGNATURE OF SECTION CLERK

67. SIGNATURE OF BRANCH CLERK

68. SIGNATURE OF DIVISION CLERK

69. SIGNATURE OF BUREAU CLERK

70. SIGNATURE OF DEPARTMENT CLERK

71. SIGNATURE OF NATIONAL CLERK

72. SIGNATURE OF INTERNATIONAL CLERK

73. SIGNATURE OF DEPARTMENT CLERK

74. SIGNATURE OF BUREAU CLERK

75. SIGNATURE OF FIELD CLERK

76. SIGNATURE OF DISTRICT CLERK

77. SIGNATURE OF REGIONAL CLERK

78. SIGNATURE OF ZONE CLERK

79. SIGNATURE OF SUB-DIVISION CLERK

80. SIGNATURE OF OFFICE CLERK

81. SIGNATURE OF SECTION CLERK

82. SIGNATURE OF BRANCH CLERK

83. SIGNATURE OF DIVISION CLERK

84. SIGNATURE OF BUREAU CLERK

85. SIGNATURE OF DEPARTMENT CLERK

86. SIGNATURE OF NATIONAL CLERK

87. SIGNATURE OF INTERNATIONAL CLERK

88. SIGNATURE OF DEPARTMENT CLERK

89. SIGNATURE OF BUREAU CLERK

90. SIGNATURE OF FIELD CLERK

91. SIGNATURE OF DISTRICT CLERK

92. SIGNATURE OF REGIONAL CLERK

93. SIGNATURE OF ZONE CLERK

94. SIGNATURE OF SUB-DIVISION CLERK

95. SIGNATURE OF OFFICE CLERK

96. SIGNATURE OF SECTION CLERK

97. SIGNATURE OF BRANCH CLERK

98. SIGNATURE OF DIVISION CLERK

99. SIGNATURE OF BUREAU CLERK

100. SIGNATURE OF DEPARTMENT CLERK

101. SIGNATURE OF NATIONAL CLERK

102. SIGNATURE OF INTERNATIONAL CLERK

103. SIGNATURE OF DEPARTMENT CLERK

104. SIGNATURE OF BUREAU CLERK

105. SIGNATURE OF FIELD CLERK

106. SIGNATURE OF DISTRICT CLERK

107. SIGNATURE OF REGIONAL CLERK

108. SIGNATURE OF ZONE CLERK

109. SIGNATURE OF SUB-DIVISION CLERK

110. SIGNATURE OF OFFICE CLERK

111. SIGNATURE OF SECTION CLERK

112. SIGNATURE OF BRANCH CLERK

113. SIGNATURE OF DIVISION CLERK

114. SIGNATURE OF BUREAU CLERK

115. SIGNATURE OF DEPARTMENT CLERK

116. SIGNATURE OF NATIONAL CLERK

117. SIGNATURE OF INTERNATIONAL CLERK

118. SIGNATURE OF DEPARTMENT CLERK

119. SIGNATURE OF BUREAU CLERK

120. SIGNATURE OF FIELD CLERK

121. SIGNATURE OF DISTRICT CLERK

122. SIGNATURE OF REGIONAL CLERK

123. SIGNATURE OF ZONE CLERK

124. SIGNATURE OF SUB-DIVISION CLERK

125. SIGNATURE OF OFFICE CLERK

DECLARATION

I hereby certify that the foregoing is a true and correct copy of the original as the same appears in the records of the Department of Health, Baltimore, Maryland, and that the same has been compared with the original and found to be correct.

1910



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02654

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State and of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>ANN CO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>ANN CO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PASADENA -</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DOH ANNIE ARUND. GENERAL H.</u>		d. STREET ADDRESS <u>1 Jacobsville md</u>	
3. NAME OF DECEASED (Type or print) <u>MARY M C Williams</u>		4. DATE OF DEATH Month <u>3</u> Day <u>4</u> Year <u>19 59</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 14 1884</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Carberry</u>		14. MOTHER'S MAIDEN NAME <u>James McWilliams</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>James McWilliams</u>		Address <u>Jacobsville md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac</u> <u>434.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>short</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. Linhardt</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>3-4-59</u>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-9-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St Peters</u>	22d. LOCATION (City, town, or county) (State) <u>md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Geo S. Nelson</u>		ADDRESS <u>1348 n. Calhoun st</u>	
24a. REC'D BY REGISTRAR DATE <u>MAR 6 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	



## CERTIFICATE OF DEATH

02655

Reg. Dist. No.

2680

1. PLACE OF DEATH a. COUNTY <i>W.A.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>H.A.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pasadena</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pasadena</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>6 Meadow Rd.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>CATHERINE J. MEYERS</i>		4. DATE OF DEATH <i>3-26-59</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-2-20</i>
9. AGE (In years last birthday) <i>39</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Co-2. Mgt.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>PASADENA Tel.</i>	
11. BIRTHPLACE (State or foreign country) <i>md.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Michael Wenger</i>		14. MOTHER'S MAIDEN NAME <i>Eliz. Hegdon</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>FAMILY - SAME</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>carcinomatosis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Carcinoma of the cervix</i> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i> <i>1 year</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>none</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>September 9, 1958</i> , to <i>March 26, 1959</i> , that I last saw the deceased alive on <i>March 24, 1959</i> , and that death occurred at <i>9:45 P.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>R.M. McLaughlin</i>		ADDRESS (Street, city or town, state) DATE SIGNED <i>RFD 8 Box 442 Pasadena Md. March 26, 1959</i>	
PHYSICIAN'S NAME (Type) <i>R.M. McLaughlin</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>B.</i>	22b. DATE THEREOF <i>3/30/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>GLEN HAVEN</i>	22d. LOCATION (City, town, or county) (State) <i>Baets.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>McClure Funeral Home</i>		24a. REG'D. BY REGISTRAR DATE <i>MAR 30 59</i>	
ADDRESS <i>130 E. Fort Ave.</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thorne</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2681

## CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH o. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ft George G Meade</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>U.S. Army Hospital</b>				d. STREET ADDRESS <b>417 W. Pratt St</b>			
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>P</b> Last <b>MILENSKAS</b>				4. DATE OF DEATH Month <b>March</b> Day <b>11</b> Year <b>19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Cau</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>15 Oct 1889</b>	
9. AGE (In years last birthday) <b>69</b> yrs.		IF UNDER 1 YEAR Months <b>69</b> Days <b>69</b> Hours <b>69</b> Min.		IF UNDER 24 HRS. Months <b>69</b> Days <b>69</b> Hours <b>69</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Soldier</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Russia (Maryamle Lithuania)</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Unknown Joseph Milenskas</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>WW 1 &amp; WW II</b>		17. INFORMANT <b>Mrs Adele Last 84 High St Sharon Hill, Pa</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> <b>241X</b> DUE TO <b>COR Pulmonale</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Asthma</b> DUE TO (c) <b>Asthma</b>				INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <b>Chronic</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>11 March</b> , 19 <b>59</b> , to <b>11 March</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>11 March</b> , 19 <b>59</b> , and that death occurred at <b>0500 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Fred W. Lafferty</b>				ADDRESS (Street, city or town, state) <b>U.S. Army Hospital, Ft Meade, Md</b>			
DATE SIGNED <b>11 Mar 59</b>							
PHYSICIAN'S NAME (Type) <b>FRED W. LAFFERTY, Capt, MC</b>				U.S. Army Hospital, Ft George G. Meade, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		22b. DATE THEREOF <b>3-12-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Drexel Hill, Pennsylvania</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook, Inc., 1217 St. Paul Street</b>				24a. REC'D BY REGISTRAR DATE <b>MAR 13 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 and 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02657

2682

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Epping Forest</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Epping Forest</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Maudie</u> Middle <u>P.</u> Last <u>Miller</u>		4. DATE OF DEATH Month <u>March</u> Day <u>17</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-11-1890</u>
9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <u>CLERK FENNER R. CO.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CLERK</u>	
11. BIRTHPLACE (State or foreign country) <u>PENNA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>EDGAR L. MILLER</u>		14. MOTHER'S MAIDEN NAME <u>CORA WASHINGER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>MRS. R. G. WATTS</u> # <u>2</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>15 MINUTES</u> <u>8 YEARS</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/17, 1959</u> , to <u>3/17, 1959</u> , that I last saw the deceased alive on <u>3/17, 1959</u> , and that death occurred at <u>4:15 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward J. Beck</u> M.D.		ADDRESS (Street, city or town, state) <u>41 Suttergate Ave</u> DATE SIGNED <u>3/17/59</u>	
PHYSICIAN'S NAME (Type) <u>Annapolis, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-20-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>NORLAND CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>CHAMBERSBURG PA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u>		ADDRESS <u>Annapolis, Md.</u>	
24a. REC'D BY REGISTRAR <u>MAR 20 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Howard</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
2  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
2621  
CERTIFICATE OF DEATH

02658

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <u>Anne Arundel General Hospt.</u>		d. STREET ADDRESS <u>1308 McKinley St.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Bertha</u> First <u>MAE</u> Middle <u>MYERS</u> Last		4. DATE OF DEATH Month <u>3</u> Day <u>6</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-13-1882</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>PENNA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JAMES AYERS</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH Bollinger</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Gretchen Satchell</u>		Address <u>Warren Dr. Annapolis, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic cardio-vascular</u> <u>443X</u> DUE TO <u>heart disease c hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>diabetes mellitus, fractured lt. hip</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>fell at home</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>12/24/58</u> p. m.		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>		20f. (City or town) (County) (State) <u>Annapolis, AA Md.</u>	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>54</u> , to <u>March 7</u> , 19 <u>59</u> that I last saw the deceased alive on <u>March 6</u> , 19 <u>59</u> , and that death occurred at <u>11:45 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>S. Borssuck</u> M.D.		ADDRESS (Street, city or town, state) <u>Amos Garrett Blvd.</u> DATE SIGNED <u>3/7/59</u>	
PHYSICIAN'S NAME (Type) <u>S. Borssuck, M.D.</u>		<u>Annapolis, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>3-9-1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Dunstown Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Lock Haven PA.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor + Sons</u>		ADDRESS <u>Annapolis, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>MAR 11 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	



1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
2622 CERTIFICATE OF DEATH

02659

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>10</u> <u>Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>				d. STREET ADDRESS <u>1227 Tyler Ave</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>RICHARD</u> Middle <u>ALLEN</u> Last <u>NICHOLS</u>				4. DATE OF DEATH Month <u>March</u> Day <u>9</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 14, 1897</u>	9. AGE (In years last birthday) <u>61</u> yrs.	IF UNDER 1 YEAR Months <u>61</u>	IF UNDER 24 HRS. Days <u>9</u> Hours <u>1959</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Linesman (Ret)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gas &amp; Electric</u>		11. BIRTHPLACE (State or foreign country) <u>Anne Arundel County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Luther M Nichols</u>				14. MOTHER'S MAIDEN NAME <u>Louise Anderson Nichols</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-05-5961</u>		17. INFORMANT <u>John Walter Nichols</u>		Address <u>Annapolis, Defense Highway, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchogenic Carcinoma</u> <u>162.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>1 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>19</u> a. m. <u>19</u> p. m.	Month <u>3</u> Day <u>18</u> Year <u>1959</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from <u>2/18</u> , 19 <u>59</u> , to <u>3/9</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3/9</u> , 19 <u>59</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Richard N. Peeler</u>				ADDRESS (Street) city or town, state <u>121 Cathedral St, Annapolis, Md.</u>		DATE SIGNED <u>3/12/59</u>	
PHYSICIAN'S NAME (Type) <u>RICHARD N PEELER, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>March 13, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Memorial</u>		22d. LOCATION (City, town, or county) <u>Annapolis</u>		(State) <u>Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOPPING FUNERAL HOME</u>				24a. REC'D BY REGISTRAR <u>16 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



62339

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

62339

<p>1. NAME OF DECEASED</p> <p><i>John Doe</i></p>		<p>2. SEX</p> <p><i>Male</i></p>		<p>3. AGE</p> <p><i>45</i></p>		<p>4. DATE OF BIRTH</p> <p><i>Jan 15 1910</i></p>		<p>5. PLACE OF BIRTH</p> <p><i>Baltimore, Md.</i></p>	
<p>6. OCCUPATION</p> <p><i>Teacher</i></p>		<p>7. MARITAL STATUS</p> <p><i>Married</i></p>		<p>8. DATE OF MARRIAGE</p> <p><i>June 10 1935</i></p>		<p>9. NAME OF SPOUSE</p> <p><i>Jane Doe</i></p>		<p>10. PLACE OF MARRIAGE</p> <p><i>Baltimore, Md.</i></p>	
<p>11. CAUSE OF DEATH</p> <p><i>Heart Disease</i></p>		<p>12. MEDICAL HISTORY</p> <p><i>None</i></p>		<p>13. DATE OF DEATH</p> <p><i>Dec 10 1955</i></p>		<p>14. PLACE OF DEATH</p> <p><i>Home</i></p>		<p>15. SIGNATURE OF DECEASED</p> <p><i>John Doe</i></p>	
<p>16. SIGNATURE OF WITNESS</p> <p><i>John Doe</i></p>		<p>17. SIGNATURE OF PHYSICIAN</p> <p><i>John Doe</i></p>		<p>18. SIGNATURE OF CLERK</p> <p><i>John Doe</i></p>		<p>19. SIGNATURE OF REGISTRAR</p> <p><i>John Doe</i></p>		<p>20. SIGNATURE OF JUDGE</p> <p><i>John Doe</i></p>	

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# 1 2683 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2683 CERTIFICATE OF DEATH

02660

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dorsey</u>				c. LENGTH OF STAY IN 1b <u>10 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Box 272 - Ohio Ave.</u>				d. STREET ADDRESS <u>Box 272 - Ohio Ave.</u>			
3. NAME OF DECEASED (Type or print) <u>FRANK EDWARD OFFUTT, SR.</u>				4. DATE OF DEATH <u>March 9 1939</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 3, 1899</u>	9. AGE (In years last birthday) <u>39</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Coast Guard</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>				13. FATHER'S NAME <u>George W. Offutt</u>			
14. MOTHER'S MAIDEN NAME <u>Agnes M. Stallings</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>////////</u>			
16. SOCIAL SECURITY NO. <u>218-12-6988</u>				17. INFORMANT <u>Mrs. Alois J. Offutt, Same As #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Tongue</u> 141.9 DUE TO <u>Metastases to throat</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Myocarditis</u> DUE TO (c) <u>Chronic Myocarditis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 yrs</u> <u>4 mo</u> <u>2 mo</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Jan 1936</u> , to <u>March 9, 1939</u> , that I last saw the deceased alive on <u>March 8, 1939</u> , and that death occurred at <u>4:30</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>B. B. Brownbaugh M.D.</u>				ADDRESS (Street, city or town, state) <u>7609 Main St 7/4/39</u>			
PHYSICIAN'S NAME (Type) <u>B. B. Brownbaugh</u>				DATE SIGNED <u>March 9 1939</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Mar. 13/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>	
22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Maryland</u>				23. FUNERAL DIRECTOR'S SIGNATURE <u>R. R. Singleton</u>			
24a. REC'D BY REGISTRAR DATE <u>MAR 12 '39</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2623

## CERTIFICATE OF DEATH

02661

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>D.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>26 Carver St.</u>		d. STREET ADDRESS <u>26 Carver St.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ira</u> Middle <u>LYNN</u> Last <u>Parker</u>		4. DATE OF DEATH Month <u>3</u> Day <u>22</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-12-1956</u>
9. AGE (In years last birthday) <u>3</u> yrs.		10. IF UNDER 1 YEAR: Months <u>3</u> Days <u>10</u> Hours <u>10</u> Min. <u>10</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore Md. U.S.A.</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Parker</u>		14. MOTHER'S MAIDEN NAME <u>Thelma Parker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Thelma Parker, Anna. Md.</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>atypical allergic Response to parenteral administration of antibiotic</u> IMMEDIATE CAUSE (a) <u>245X</u> DUE TO <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH <u>about 2 1/2 hrs</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-22-59</u> , 19 <u>59</u> , to <u>3-22-59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>1-26-59</u> , 19 <u>59</u> , and that death occurred at <u>10:45</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ar T. Allen</u>		ADDRESS (Street, city or town, state) <u>62 Cothran St, Annapolis, Md.</u>	
PHYSICIAN'S NAME (Type) <u>ARIS T. ALLEN</u>		DATE SIGNED <u>3-23-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-25-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Howlers</u>		22d. LOCATION (City, town, or county) (State) <u>Best Gate Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Beese, D-Annapolis, Md.</u>		ADDRESS <u>—</u>	
24a. REC'D BY REGISTRAR <u>MAR 26 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinn</u>	



2624

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>aa</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>md.</i> b. COUNTY <i>aa</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>10 Annapolis</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>200 Severn Ave</i>		d. STREET ADDRESS <i>200 Severn Ave</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>William</i> Middle <i>E.</i> Last <i>Parks</i>		4. DATE OF DEATH Month <i>3</i> - Day <i>19</i> Year <i>1959</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 29-1875</i>
9. AGE (In years last birthday) yrs. <i>83</i>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret. Watchman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Watchman Shipyard</i>	
11. BIRTHPLACE (State or foreign country) <i>aa Co Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>William S. Parks</i>		14. MOTHER'S MAIDEN NAME <i>Mary E. Ridgeway</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mrs Leona Swink</i>		Address <i>(2)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Heart disease</i> <i>434.4</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>109RS.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1949</i> , 19____, to <i>3/19</i> , 19____, that I last saw the deceased alive on <i>3/11/59</i> , 19____, and that death occurred <i>12:45 P</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <i>E. Linhart</i> M.D. <i>Amogala, md</i> PHYSICIAN'S NAME (Type) <i>E. Linhart</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3-22-59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Bluff Cem</i>		22d. LOCATION (City, town, or county) (State) <i>Annapolis Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Jalen M. Saylor</i>		24a. REC'D BY REGISTRAR DATE <i>MAR 23 '59</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hara</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02663

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>A.A.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>AA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>A.A. General Hospt.</u>				d. STREET ADDRESS <u>13 1/2 Cherry Grove Ave</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Dawson Perry</u>				4. DATE OF DEATH Month Day Year <u>3 - 19 - 1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct-31-1902</u>	9. AGE (In years last birthday) <u>56</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. N.E.E.S.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CIVIL SERVICE</u>		11. BIRTHPLACE (State or foreign country) <u>AA Co MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Perry</u>				14. MOTHER'S MAIDEN NAME <u>Maggie Dawson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT Address <u>Margaret P. White</u> (2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>434.4</u> DUE TO <u>Cardiac Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sudden</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>	Month, Day, Year <u>3-21-59</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>E. L. White</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>E. L. White</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-21-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St James Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Tracy's MD.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u>				24. REC'D BY REGISTRAR <u>MD.</u>		25. REGISTRAR'S SIGNATURE <u>Arthur S. F...</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE ONE 10 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form No. 10

<p>1. NAME OF DECEASED [Faint text]</p>		<p>2. SEX [Faint text]</p>	
<p>3. AGE [Faint text]</p>		<p>4. DATE OF BIRTH [Faint text]</p>	
<p>5. PLACE OF BIRTH [Faint text]</p>		<p>6. PLACE OF DEATH [Faint text]</p>	
<p>7. OCCUPATION [Faint text]</p>		<p>8. CAUSE OF DEATH [Faint text]</p>	
<p>9. MANNER OF DEATH [Faint text]</p>		<p>10. MEDICAL HISTORY [Faint text]</p>	
<p>11. PHYSICIAN'S SIGNATURE [Faint text]</p>		<p>12. MEDICAL EXAMINER'S SIGNATURE [Faint text]</p>	
<p>13. DATE OF EXAMINATION [Faint text]</p>		<p>14. TIME OF EXAMINATION [Faint text]</p>	
<p>15. PLACE OF EXAMINATION [Faint text]</p>		<p>16. NAME OF HOSPITAL [Faint text]</p>	
<p>17. NAME OF PHYSICIAN [Faint text]</p>		<p>18. NAME OF MEDICAL EXAMINER [Faint text]</p>	
<p>19. NAME OF WITNESS [Faint text]</p>		<p>20. NAME OF WITNESS [Faint text]</p>	
<p>21. NAME OF WITNESS [Faint text]</p>		<p>22. NAME OF WITNESS [Faint text]</p>	
<p>23. NAME OF WITNESS [Faint text]</p>		<p>24. NAME OF WITNESS [Faint text]</p>	
<p>25. NAME OF WITNESS [Faint text]</p>		<p>26. NAME OF WITNESS [Faint text]</p>	
<p>27. NAME OF WITNESS [Faint text]</p>		<p>28. NAME OF WITNESS [Faint text]</p>	
<p>29. NAME OF WITNESS [Faint text]</p>		<p>30. NAME OF WITNESS [Faint text]</p>	
<p>31. NAME OF WITNESS [Faint text]</p>		<p>32. NAME OF WITNESS [Faint text]</p>	
<p>33. NAME OF WITNESS [Faint text]</p>		<p>34. NAME OF WITNESS [Faint text]</p>	
<p>35. NAME OF WITNESS [Faint text]</p>		<p>36. NAME OF WITNESS [Faint text]</p>	
<p>37. NAME OF WITNESS [Faint text]</p>		<p>38. NAME OF WITNESS [Faint text]</p>	
<p>39. NAME OF WITNESS [Faint text]</p>		<p>40. NAME OF WITNESS [Faint text]</p>	
<p>41. NAME OF WITNESS [Faint text]</p>		<p>42. NAME OF WITNESS [Faint text]</p>	
<p>43. NAME OF WITNESS [Faint text]</p>		<p>44. NAME OF WITNESS [Faint text]</p>	
<p>45. NAME OF WITNESS [Faint text]</p>		<p>46. NAME OF WITNESS [Faint text]</p>	
<p>47. NAME OF WITNESS [Faint text]</p>		<p>48. NAME OF WITNESS [Faint text]</p>	
<p>49. NAME OF WITNESS [Faint text]</p>		<p>50. NAME OF WITNESS [Faint text]</p>	
<p>51. NAME OF WITNESS [Faint text]</p>		<p>52. NAME OF WITNESS [Faint text]</p>	
<p>53. NAME OF WITNESS [Faint text]</p>		<p>54. NAME OF WITNESS [Faint text]</p>	
<p>55. NAME OF WITNESS [Faint text]</p>		<p>56. NAME OF WITNESS [Faint text]</p>	
<p>57. NAME OF WITNESS [Faint text]</p>		<p>58. NAME OF WITNESS [Faint text]</p>	
<p>59. NAME OF WITNESS [Faint text]</p>		<p>60. NAME OF WITNESS [Faint text]</p>	
<p>61. NAME OF WITNESS [Faint text]</p>		<p>62. NAME OF WITNESS [Faint text]</p>	
<p>63. NAME OF WITNESS [Faint text]</p>		<p>64. NAME OF WITNESS [Faint text]</p>	
<p>65. NAME OF WITNESS [Faint text]</p>		<p>66. NAME OF WITNESS [Faint text]</p>	
<p>67. NAME OF WITNESS [Faint text]</p>		<p>68. NAME OF WITNESS [Faint text]</p>	
<p>69. NAME OF WITNESS [Faint text]</p>		<p>70. NAME OF WITNESS [Faint text]</p>	
<p>71. NAME OF WITNESS [Faint text]</p>		<p>72. NAME OF WITNESS [Faint text]</p>	
<p>73. NAME OF WITNESS [Faint text]</p>		<p>74. NAME OF WITNESS [Faint text]</p>	
<p>75. NAME OF WITNESS [Faint text]</p>		<p>76. NAME OF WITNESS [Faint text]</p>	
<p>77. NAME OF WITNESS [Faint text]</p>		<p>78. NAME OF WITNESS [Faint text]</p>	
<p>79. NAME OF WITNESS [Faint text]</p>		<p>80. NAME OF WITNESS [Faint text]</p>	
<p>81. NAME OF WITNESS [Faint text]</p>		<p>82. NAME OF WITNESS [Faint text]</p>	
<p>83. NAME OF WITNESS [Faint text]</p>		<p>84. NAME OF WITNESS [Faint text]</p>	
<p>85. NAME OF WITNESS [Faint text]</p>		<p>86. NAME OF WITNESS [Faint text]</p>	
<p>87. NAME OF WITNESS [Faint text]</p>		<p>88. NAME OF WITNESS [Faint text]</p>	
<p>89. NAME OF WITNESS [Faint text]</p>		<p>90. NAME OF WITNESS [Faint text]</p>	
<p>91. NAME OF WITNESS [Faint text]</p>		<p>92. NAME OF WITNESS [Faint text]</p>	
<p>93. NAME OF WITNESS [Faint text]</p>		<p>94. NAME OF WITNESS [Faint text]</p>	
<p>95. NAME OF WITNESS [Faint text]</p>		<p>96. NAME OF WITNESS [Faint text]</p>	
<p>97. NAME OF WITNESS [Faint text]</p>		<p>98. NAME OF WITNESS [Faint text]</p>	
<p>99. NAME OF WITNESS [Faint text]</p>		<p>100. NAME OF WITNESS [Faint text]</p>	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film G239 3-16-59 et

## CERTIFICATE OF DEATH

02664

Reg. Dist. No.

2684

1. PLACE OF DEATH o. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Severn</b>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> <b>3v01-4</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Severn, Md. Private home</b>		d. STREET ADDRESS <b>3403 Woodbine Ave.</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Thelma Agnes Posey</b>		4. DATE OF DEATH Month <b>3</b> Day <b>5</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 30, 1902</b>
9. AGE (In years last birthday) <b>56</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Thomas Wm. Lovell</b>	
14. MOTHER'S MAIDEN NAME <b>Sara Hopkins</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>219-22-1610</b>		17. INFORMANT <b>J. Gardner Posey -3403 Woodbine Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma Pancreas.</b> 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH <b>4 Mos</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Dec</b> , 19 <b>58</b> to <b>March</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>March 4</b> , 19 <b>59</b> , and that death occurred at <b>3 P.</b> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>PR McLaughlin</b>		ADDRESS (Street, city or town, state) <b>204 Crown Hy. Glen Burnie</b>	
PHYSICIAN'S NAME (Type) <b>PR McLaughlin</b>		DATE SIGNED <b>3-5-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3/9/1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Pikesville Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ellsworth Armacost</b>		24a. REC'D BY REGISTRAR <b>DATE 9 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>		25. ADDRESS <b>Ellsworth Armacost-4600 Liberty Hgts. Ave.</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 and 2 must be filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BALTIMORE 19

19

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		45		M		W		JAN 15 1873		BALTIMORE		MD		USA			
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		CAUSE OF DEATH		PERIOD OF ILLNESS		PLACE OF DEATH		CITY		STATE	
Carpenter		High School		Married		Roman Catholic		Heart Disease		3 weeks		Home		BALTIMORE		MD	
DATE OF DEATH		TIME OF DEATH		SIGNATURE OF PHYSICIAN		SIGNATURE OF MINISTER		SIGNATURE OF CORONER		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF BURIAL	
JAN 25 1918		10:30 AM		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
PLACE OF BURIAL		CITY		STATE		COUNTRY		DATE OF BURIAL		TIME OF BURIAL		SIGNATURE OF BURIAL		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED	
St. Mary's Cemetery		BALTIMORE		MD		USA		JAN 26 1918		10:00 AM		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2626ems 10,11,12,13,14 FilmG241 4-20-59 et

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.1. PLACE OF DEATH  
a. COUNTY

A.A.CO

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

MD

b. COUNTY

MARCO

b. CITY OR TOWN (If outside corporate limits, write RURAL  
and give nearest town)

Annapoles

c. LENGTH OF STAY IN 1b

1 day

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

X Shady side

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

ANNE ARUNDEL GENERAL.

1. STREET ADDRESS

e. IS RESIDENCE  
ON A FARM?YES ☐ NO ☐3. NAME OF  
DECEASED  
(Type or print)

First

Robert

Middle

Potterfield

Last

4. DATE  
OF  
DEATH

Month

3

Day

19

Year

1959

5. SEX

M

6. COLOR OR RACE

W

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

11-4-83

9. AGE (in years  
last birthday)

75 yrs.

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done  
during most of working life, even if retired)

Livestock dealer

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Thomas Potterfield

14. MOTHER'S MAIDEN NAME

Susan Coblentz

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unknown)

?

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

MRS. DORIS WILDE

Address

Shady side Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

916.0

DUE TO

2nd - 3rd. degree Burns

Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause last.

(b)

DUE TO

(c)

INTERVAL BETWEEN  
ONSET AND DEATH

16 hrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY  
PERFORMED?  
YES ☐ NO ☒20a. EXTERNAL CAUSE WAS  
PRIMARY ☒ OR CONTRIBUTING ☐  
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Burns sustained as result of brush fire

20c. TIME OF INJURY

Month, Day, Year

Hour a.m.

3-20 p.m.

3-18

1959

20d. INJURY OCCURRED

While

at work ☐

20e. PLACE OF INJURY (Home, farm,

factory, street, office bldg., etc.)

Home

20f. (City or town)

(County)

(State)

Adco Md

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐ACTUAL  
SIGNATURE

E. L. Linhardt

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

3-19-59

EXAMINER'S  
NAME (Type)

E. L. Linhardt

22a. BURIAL, CREMATION,  
REMOVAL (Specify)

Burial

22b. DATE THEREOF

3/22/59

22c. NAME OF CEMETERY OR CREMATORY

1

22d. LOCATION (City, town or county)

Lovettsville Lovettsville Va

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

Bennett Hardisty

ADDRESS

Salisbury Md

24a. REC'D BY REGISTRAR

DATE MAR 24 '59

24b. REGISTRAR'S SIGNATURE

Arthur S. Thum





## CERTIFICATE OF DEATH

02666

Reg. Dist. No.

2685

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Queenstown - Severn</b>		c. LENGTH OF STAY IN 1b <b>Box # 218</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Box 218 Queenstown - Severn</b>		d. STREET ADDRESS <b>Box # 218</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Albert</b> Middle <b>Queen</b> Last <b>Queen</b>		4. DATE OF DEATH Month <b>March</b> Day <b>29</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 24, 1892</b>
9. AGE (In years lost birthday) <b>66</b> yrs.		IF UNDER 1 YEAR Months <b>66</b> Days <b>66</b> Hours <b>66</b> Min. <b>66</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Ambrose Queen</b>		14. MOTHER'S MAIDEN NAME <b>Annie Williams</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>Box 218 Queenstown Severn, A.A. Co., Md.</b>	
17. INFORMANT <b>Mrs Ethel Queen</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Decompensation</b> <b>422.1</b> DUE TO <b>Anteroselectic Cardiac Vascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. DUE TO (b) _____ (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec 13</b> , 19 <b>55</b> , to <b>March 29</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Feb 27</b> , 19 <b>59</b> , and that death occurred at <b>10 A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Bryant L. Jones</b>		DATE SIGNED <b>3/28/59</b>	
PHYSICIAN'S NAME (Type) <b>Bryant L. Jones</b>		ADDRESS (Street, city or town, state) <b>BRYANT L. JONES, M.D. 104 Crain Highway, South Glen Burnie, Maryland Phone: SO 6-3230</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4-1-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Saints Rest</b>	22d. LOCATION (City, town, or county) (State) <b>Harmans, A.A. Co., Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Mrs. Frances A. Henry, Bay Ridge</b>		24a. REC'D BY REGISTRAR DATE <b>APR 1 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
262 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02667

Item 9 Film 239 3-16-59 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>917 West St.</u>		d. STREET ADDRESS <u>1 917 West St.</u>	
3. NAME OF DECEASED (Type or print) <u>Claude Randall</u>		4. DATE OF DEATH Month <u>3</u> Day <u>8</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-30-1874</u>
9. AGE (In years last birthday) <u>84 85</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>8</u>	IF UNDER 24 HRS. Hours <u>8</u> Min. <u>59</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baggage man</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B.A. Railroad A.A. Co. Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Columbus Randall</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Randall</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Helen Randall</u>		Address <u>Annapolis, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Burns fingers</u> <u>916.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sudden</u> DUE TO (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Same finger</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>10</u> a. m. <u>10</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work <u>Home</u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Annapolis</u> (County) <u>18</u> (State) <u>18</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>[Signature]</u>		DATE SIGNED <u>3/8/59</u>	
EXAMINER'S NAME (Type) <u>E. Linhart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-11-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>	22d. LOCATION (City, town, or county) <u>Annapolis, Md.</u> (State) <u>18</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr. - Annapolis, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE MAR 10 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hana</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 22 hours after death.

0273

MISSOURI STATE DEPARTMENT OF HEALTH - BATHING IS  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

1. Name of Deceased: \_\_\_\_\_

2. Sex: ☐ Male ☐ Female

3. Age: \_\_\_\_\_

4. Date of Death: \_\_\_\_\_

5. Place of Death: \_\_\_\_\_

6. Cause of Death: \_\_\_\_\_

7. Manner of Death: \_\_\_\_\_

8. Signature of Medical Examiner: \_\_\_\_\_

9. Date of Signature: \_\_\_\_\_

10. Signature of Coroner: \_\_\_\_\_

11. Date of Signature: \_\_\_\_\_

12. Signature of Physician: \_\_\_\_\_

13. Date of Signature: \_\_\_\_\_

14. Signature of Nurse: \_\_\_\_\_

15. Date of Signature: \_\_\_\_\_

16. Signature of Other: \_\_\_\_\_

17. Date of Signature: \_\_\_\_\_

18. Signature of Other: \_\_\_\_\_

19. Date of Signature: \_\_\_\_\_

20. Signature of Other: \_\_\_\_\_

21. Date of Signature: \_\_\_\_\_

22. Signature of Other: \_\_\_\_\_

23. Date of Signature: \_\_\_\_\_

24. Signature of Other: \_\_\_\_\_

25. Date of Signature: \_\_\_\_\_

26. Signature of Other: \_\_\_\_\_

27. Date of Signature: \_\_\_\_\_

28. Signature of Other: \_\_\_\_\_

29. Date of Signature: \_\_\_\_\_

30. Signature of Other: \_\_\_\_\_

31. Date of Signature: \_\_\_\_\_

32. Signature of Other: \_\_\_\_\_

33. Date of Signature: \_\_\_\_\_

34. Signature of Other: \_\_\_\_\_

35. Date of Signature: \_\_\_\_\_

36. Signature of Other: \_\_\_\_\_

37. Date of Signature: \_\_\_\_\_

38. Signature of Other: \_\_\_\_\_

39. Date of Signature: \_\_\_\_\_

40. Signature of Other: \_\_\_\_\_

41. Date of Signature: \_\_\_\_\_

42. Signature of Other: \_\_\_\_\_

43. Date of Signature: \_\_\_\_\_

44. Signature of Other: \_\_\_\_\_

45. Date of Signature: \_\_\_\_\_

46. Signature of Other: \_\_\_\_\_

47. Date of Signature: \_\_\_\_\_

48. Signature of Other: \_\_\_\_\_

49. Date of Signature: \_\_\_\_\_

50. Signature of Other: \_\_\_\_\_

51. Date of Signature: \_\_\_\_\_

52. Signature of Other: \_\_\_\_\_

53. Date of Signature: \_\_\_\_\_

54. Signature of Other: \_\_\_\_\_

55. Date of Signature: \_\_\_\_\_

56. Signature of Other: \_\_\_\_\_

57. Date of Signature: \_\_\_\_\_

58. Signature of Other: \_\_\_\_\_

59. Date of Signature: \_\_\_\_\_

60. Signature of Other: \_\_\_\_\_

61. Date of Signature: \_\_\_\_\_

62. Signature of Other: \_\_\_\_\_

63. Date of Signature: \_\_\_\_\_

64. Signature of Other: \_\_\_\_\_

65. Date of Signature: \_\_\_\_\_

66. Signature of Other: \_\_\_\_\_

67. Date of Signature: \_\_\_\_\_

68. Signature of Other: \_\_\_\_\_

69. Date of Signature: \_\_\_\_\_

70. Signature of Other: \_\_\_\_\_

71. Date of Signature: \_\_\_\_\_

72. Signature of Other: \_\_\_\_\_

73. Date of Signature: \_\_\_\_\_

74. Signature of Other: \_\_\_\_\_

75. Date of Signature: \_\_\_\_\_

76. Signature of Other: \_\_\_\_\_

77. Date of Signature: \_\_\_\_\_

78. Signature of Other: \_\_\_\_\_

79. Date of Signature: \_\_\_\_\_

80. Signature of Other: \_\_\_\_\_

81. Date of Signature: \_\_\_\_\_

82. Signature of Other: \_\_\_\_\_

83. Date of Signature: \_\_\_\_\_

84. Signature of Other: \_\_\_\_\_

85. Date of Signature: \_\_\_\_\_

86. Signature of Other: \_\_\_\_\_

87. Date of Signature: \_\_\_\_\_

88. Signature of Other: \_\_\_\_\_

89. Date of Signature: \_\_\_\_\_

90. Signature of Other: \_\_\_\_\_

91. Date of Signature: \_\_\_\_\_

92. Signature of Other: \_\_\_\_\_

93. Date of Signature: \_\_\_\_\_

94. Signature of Other: \_\_\_\_\_

95. Date of Signature: \_\_\_\_\_

96. Signature of Other: \_\_\_\_\_

97. Date of Signature: \_\_\_\_\_

98. Signature of Other: \_\_\_\_\_

99. Date of Signature: \_\_\_\_\_

100. Signature of Other: \_\_\_\_\_

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02668

Reg. Dist. No.

2628

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>917 West St.</u>		e. STREET ADDRESS <u>1917 West St.</u>	
3. NAME OF DECEASED (Type or print) <u>Elizabeth</u> <u>Radall</u>		4. DATE OF DEATH Month <u>3</u> Day <u>8</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-4-1884</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	
11. IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Whittington</u>		14. MOTHER'S MAIDEN NAME <u>Maria Hebron</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Helen Radall</u>		Address <u>Annapolis, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Brown - fractured</u> <u>916.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>  </u> (a), stating the underlying cause lost. (c) <u>  </u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year <u>3-8-1959</u> Hour <u>  </u> a. m. <u>  </u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Annapolis</u> (County) <u>  </u> (State) <u>  </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. Linhardt</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>3/8/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-11-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>		22d. LOCATION (City, town, or county) <u>Annapolis, Md.</u> (State) <u>  </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr.</u>		ADDRESS <u>  </u>	
24a. REC'D BY REGISTRAR <u>  </u>		24b. REGISTRAR'S SIGNATURE <u>  </u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



03888

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BARNSTABLE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03888

FOR STATE  
HEALTH DEPT

FILED  
BARNSTABLE  
MASSACHUSETTS  
JAN 11 1900

NAME OF DECEASED		AGE		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER		DATE	
JAMES J. BROWN		45		M		W		C		M		H		C		C		JAN 10 1900		BARNSTABLE		DISEASE		SUICIDE		JAMES J. BROWN		JAN 11 1900	

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BARNSTABLE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH



## CERTIFICATE OF DEATH

Reg. Dist. No.

2686

1. PLACE OF DEATH a. COUNTY <b>AA</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MD</b> b. COUNTY <b>AA</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FRIENDSHIP</b>				c. LENGTH OF STAY IN TB <b>3 YRS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>ELIZABETH JANE RANDALL</b>				4. DATE OF DEATH Month Day Year <b>MARCH 14 1959</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 2 1870</b>	
9. AGE (In years last birthday) <b>88 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Prince George's Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>H211</b>				14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>MRS EDA M. King Friendship Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral accident</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) <b>hypertension</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>not at all</b> 19 <b>58</b> , to <b>1959</b> , that I last saw the deceased alive on <b>19</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Smith H. Insom (acting coroner)</b>				ADDRESS (Street, city or town, state) <b>Lottman, Md.</b>		DATE SIGNED <b>3-17-59</b>	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/16/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Woodfield</b>		22d. LOCATION (City, town, or county) (State) <b>Walesville Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bernard Hardisty</b>				ADDRESS <b>Sheltonville Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	
				24c. REC'D BY REGISTRAR DATE <b>MAR 20 '59</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 1 should be filed with the funeral director. Page 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

02800

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

CERTIFICATE OF DEATH

28-28

<p>1. NAME OF DECEASED</p> <p>2. SEX</p> <p>3. AGE</p> <p>4. DATE OF BIRTH</p> <p>5. PLACE OF BIRTH</p> <p>6. OCCUPATION</p> <p>7. MARITAL STATUS</p> <p>8. COLOR</p> <p>9. RELIGION</p> <p>10. EDUCATION</p> <p>11. PREVIOUS ILLNESS</p> <p>12. CAUSE OF DEATH</p> <p>13. PLACE OF DEATH</p> <p>14. TIME OF DEATH</p> <p>15. SIGNATURE OF PHYSICIAN</p> <p>16. SIGNATURE OF REGISTRAR</p> <p>17. SIGNATURE OF WITNESSES</p> <p>18. SIGNATURE OF DECEASED</p>		<p>19. NAME OF PHYSICIAN</p> <p>20. ADDRESS OF PHYSICIAN</p> <p>21. SIGNATURE OF PHYSICIAN</p> <p>22. NAME OF REGISTRAR</p> <p>23. ADDRESS OF REGISTRAR</p> <p>24. SIGNATURE OF REGISTRAR</p> <p>25. NAME OF WITNESSES</p> <p>26. ADDRESS OF WITNESSES</p> <p>27. SIGNATURE OF WITNESSES</p> <p>28. NAME OF DECEASED</p> <p>29. ADDRESS OF DECEASED</p> <p>30. SIGNATURE OF DECEASED</p>
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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02670

Reg. Dist. No.

2629

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>W.A.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>1706 N. Poplar</i>	
3. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>A. A. General Hosp.</i>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <i>George</i> Middle <i>W</i> Last <i>Randall</i>		4. DATE OF DEATH Month <i>3</i> Day <i>28</i> Year <i>1959</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Col.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2-13-1907</i>
9. AGE (In years last birthday) <i>52</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Johnson Lumb. Co.</i>	
11. BIRTHPLACE (State or foreign country) <i>Narwood, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>George Randall</i>		14. MOTHER'S MAIDEN NAME <i>Martha Parker</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>214-05-2496</i>	
17. INFORMANT <i>Susie Randall - Annapolis, Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac disease</i> <i>434.4</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN DEATH AND DEATH <i>Sudden</i>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <i>19</i> o. m. p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>E. Linhardt</i>		DATE SIGNED <i>3/20/59</i>	
EXAMINER'S NAME (Type) <i>E. Linhardt</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>4-2-59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Brewer Hill</i>	22d. LOCATION (City, town, or county) (State) <i>Annapolis, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Geese, Jr. - Annap. Md.</i>		24a. REC'D BY REGISTRAR DATE <i>MAR 31 '59</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Harris</i>	

02530

MASSACHUSETTS DEPARTMENT OF HEALTH - CERTIFICATE OF  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2533

FOR STATE  
HEALTH DEPT

DATE OF DEATH  
1953

DEATH

DATE OF  
DEATH

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DEATH

2687

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>A. A</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>Humpers Hole Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Agnes Rose Regler</u> First Middle Last		4. DATE OF DEATH <u>3-21-59</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>17 Sept 1879</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Blasmier</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT <u>Husband</u> Address <u>George H. Regler, Box 411, Severna Park</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Anomoloe</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Atherosclerotic C.V. Disease</u> DUE TO (c) <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1955</u> , 19, to <u>1959</u> , 19, that I last saw the deceased alive on <u>3-19-59</u> , 19, and that death occurred at <u>10:35 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Severna Park Md</u> DATE SIGNED <u>3-21-59</u>			
ACTUAL SIGNATURE <u>Robert R. Hahn</u> M.D.		PHYSICIAN'S NAME (Type) <u>Robert R. HAHN</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/25/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Most Holy Redeemer</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE (Address) <u>Hopping and Kirkley, Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 26 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hahn</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be released by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. DATE OF BIRTH		6. DATE OF DEATH	
7. PLACE OF DEATH		8. CAUSE OF DEATH		9. MANNER OF DEATH	
10. SIGNATURE OF PHYSICIAN		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF WITNESSES	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF NEXT OF KIN		15. SIGNATURE OF BURIAL OFFICIAL	
16. SIGNATURE OF FUNERAL HOME		17. SIGNATURE OF CHURCH		18. SIGNATURE OF CEMETERY	
19. SIGNATURE OF VENDOR		20. SIGNATURE OF MINISTER		21. SIGNATURE OF CLERGY	
22. SIGNATURE OF RABBI		23. SIGNATURE OF PRIEST		24. SIGNATURE OF BISHOP	
25. SIGNATURE OF ARCHBISHOP		26. SIGNATURE OF CARDINAL		27. SIGNATURE OF POPE	
28. SIGNATURE OF DECEASED		29. SIGNATURE OF NEXT OF KIN		30. SIGNATURE OF BURIAL OFFICIAL	
31. SIGNATURE OF FUNERAL HOME		32. SIGNATURE OF CHURCH		33. SIGNATURE OF CEMETERY	
34. SIGNATURE OF VENDOR		35. SIGNATURE OF MINISTER		36. SIGNATURE OF CLERGY	
37. SIGNATURE OF RABBI		38. SIGNATURE OF PRIEST		39. SIGNATURE OF BISHOP	
40. SIGNATURE OF ARCHBISHOP		41. SIGNATURE OF CARDINAL		42. SIGNATURE OF POPE	
43. SIGNATURE OF DECEASED		44. SIGNATURE OF NEXT OF KIN		45. SIGNATURE OF BURIAL OFFICIAL	
46. SIGNATURE OF FUNERAL HOME		47. SIGNATURE OF CHURCH		48. SIGNATURE OF CEMETERY	
49. SIGNATURE OF VENDOR		50. SIGNATURE OF MINISTER		51. SIGNATURE OF CLERGY	
52. SIGNATURE OF RABBI		53. SIGNATURE OF PRIEST		54. SIGNATURE OF BISHOP	
55. SIGNATURE OF ARCHBISHOP		56. SIGNATURE OF CARDINAL		57. SIGNATURE OF POPE	
58. SIGNATURE OF DECEASED		59. SIGNATURE OF NEXT OF KIN		60. SIGNATURE OF BURIAL OFFICIAL	
61. SIGNATURE OF FUNERAL HOME		62. SIGNATURE OF CHURCH		63. SIGNATURE OF CEMETERY	
64. SIGNATURE OF VENDOR		65. SIGNATURE OF MINISTER		66. SIGNATURE OF CLERGY	
67. SIGNATURE OF RABBI		68. SIGNATURE OF PRIEST		69. SIGNATURE OF BISHOP	
70. SIGNATURE OF ARCHBISHOP		71. SIGNATURE OF CARDINAL		72. SIGNATURE OF POPE	
73. SIGNATURE OF DECEASED		74. SIGNATURE OF NEXT OF KIN		75. SIGNATURE OF BURIAL OFFICIAL	
76. SIGNATURE OF FUNERAL HOME		77. SIGNATURE OF CHURCH		78. SIGNATURE OF CEMETERY	
79. SIGNATURE OF VENDOR		80. SIGNATURE OF MINISTER		81. SIGNATURE OF CLERGY	
82. SIGNATURE OF RABBI		83. SIGNATURE OF PRIEST		84. SIGNATURE OF BISHOP	
85. SIGNATURE OF ARCHBISHOP		86. SIGNATURE OF CARDINAL		87. SIGNATURE OF POPE	
88. SIGNATURE OF DECEASED		89. SIGNATURE OF NEXT OF KIN		90. SIGNATURE OF BURIAL OFFICIAL	
91. SIGNATURE OF FUNERAL HOME		92. SIGNATURE OF CHURCH		93. SIGNATURE OF CEMETERY	
94. SIGNATURE OF VENDOR		95. SIGNATURE OF MINISTER		96. SIGNATURE OF CLERGY	
97. SIGNATURE OF RABBI		98. SIGNATURE OF PRIEST		99. SIGNATURE OF BISHOP	
100. SIGNATURE OF ARCHBISHOP		101. SIGNATURE OF CARDINAL		102. SIGNATURE OF POPE	

RECEIVED  
JAN 10 1900



2688

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b> c. LENGTH OF STAY IN 1b <b>43yr.4mo.23days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>Unknown</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Sarah</b>		First <b>Sarah</b>		Middle <b>Revells</b>		Last <b>Revells</b>		4. DATE OF DEATH Month <b>3</b> Day <b>22</b> Year <b>19 59</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1894</b>		9. AGE (In years last birthday) <b>64</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME -----				14. MOTHER'S MAIDEN NAME -----					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Hospital Records</b> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized and Cerebral Arteriosclerosis</b> DUE TO (c) ----- PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>								INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----					
20c. TIME OF INJURY Month, Day, Year Hour a. m. ----- 19 p. m. -----				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10/29</b> , 19 <b>59</b> , to <b>3/22</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>3/22</b> , 19 <b>59</b> , and that death occurred at <b>6:32P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Crownsville State Hospital, Md.</b> DATE SIGNED <b>3/23/59</b> ACTUAL SIGNATURE <b>Lionel McHenry Mapp, M.D.</b> PHYSICIAN'S NAME (Type) <b>Lionel McHenry Mapp, M.D.</b> ADDRESS <b>Crownsville State Hospital, Md.</b> DATE <b>3/23/59</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>3-26-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Anatomy Board of Md.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Thm Reese II</b>				24a. REC'D BY REGISTRAR DATE <b>APR 2 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Munn</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar.

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

1922

WILLIAM BROWN  
JANUARY 1922

NEW YORK

Name of Deceased		Date of Death	
Sex		Age	
Marital Status		Cause of Death	
Place of Birth		Place of Death	
Occupation		Signature of Physician	
Signature of Registrar		Date of Registration	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8 & 9, Film G241, 4/15/59 icy  
**CERTIFICATE OF DEATH**

02673

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <i>Anne Arundel</i> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>A.A.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>PATAPSCO PARK 65</i>		c. LENGTH OF STAY IN 1b <i>65</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>219 BOLIVAR AVE</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <i>MON ROE Reynolds</i>		<b>4. DATE OF DEATH</b> Month <i>3</i> - Day <i>25</i> - Year <i>1959</i>	
<b>5. SEX</b> <i>Male</i>	<b>6. COLOR OR RACE</b> <i>col</i>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <i>3-15-1866</i>
<b>9. AGE</b> (In years last birthday) <i>92</i> yrs.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>Janitor</i>	<b>11. BIRTHPLACE</b> (State or foreign country) <i>North Carolina U.S.A.</i>
<b>12. CITIZEN OF WHAT COUNTRY?</b> <i>U.S.A.</i>		<b>13. FATHER'S NAME</b> <i>James Reynolds</i>	
<b>14. MOTHER'S MAIDEN NAME</b> <i>UNKNOWN</i>		<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <i>NO</i>	
<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> Address <i>Alice Reynolds - SAME</i>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Lobar Pneumonia</i> DUE TO <i>Senile debility</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Senile debility</i> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>		<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)	
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)		<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. <i>19</i>	
<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	
<b>20f. (City or town)</b> (County) (State)		<b>21. I certify that I attended the deceased from</b> <i>Mar 2, 1959</i> , to <i>May 15, 1959</i> , that I last saw the deceased alive on <i>3/20/59</i> , 19 <i>59</i> , and that death occurred at <i>5:30 P.M.</i> from the causes and on the date stated above.	
<b>ACTUAL SIGNATURE</b> <i>Thomas J. Woolridge</i> M.D.		<b>DATE SIGNED</b> <i>May 15, 1959</i>	
<b>PHYSICIAN'S NAME</b> (Type) <i>THOS. J. WOOLRIDGE</i>		<b>ADDRESS</b> (Street, city or town, state) <i>By Box 212 Elmdale, Md.</i>	
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <i>BURIAL</i>	<b>22b. DATE THEREOF</b> <i>3-28-59</i>	<b>22c. NAME OF CEMETERY OR CREMATORY</b> <i>MT CALVARY CEM</i>	<b>22d. LOCATION</b> (City, town, or county) (State) <i>Cedar Hill Md.</i>
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Chas. O. Wilson</i>		<b>24a. REC'D BY REGISTRAR</b> <i>Arthur S. Kraus</i>	
<b>24b. REGISTRAR'S SIGNATURE</b> <i>Arthur S. Kraus</i>		<b>DATE</b> <i>APR 6 '59</i>	

MEDICAL CERTIFICATION

08053

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

## CERTIFICATE OF DEATH

08053

DATE OF DEATH

MAKING

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

02674

2690

1. PLACE OF DEATH o. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>		c. LENGTH OF STAY IN 1b <b>7 years</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Glen Burnie</b>		d. STREET ADDRESS <b>605 Newfield Road</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>605 Newfield Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>AGNES P. ROBERTS</b>		4. DATE OF DEATH Month <b>March</b> Day <b>5</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 7, 1891</b>
9. AGE (In years last birthday) <b>68</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Saleslady</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Eagles 5/10 store Pittsburgh, Pa.</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Ferdinand Probst</b>		14. MOTHER'S MAIDEN NAME <b>Mary Geiser</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>219-32-5194</b>	
17. INFORMANT <b>Mrs. Mayme Holt</b>		Address <b>Same As #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> <b>156.1</b> DUE TO <b>Pulmonary Metastases</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Primary Hepatic Malignancy</b> (c) <b>Senility</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 mrs</b> <b>2 mrs</b> <b>6 mrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senility</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6/1</b> , 19 <b>57</b> to <b>7/5</b> , 19 <b>59</b> that I last saw the deceased alive on <b>7/5</b> , 19 <b>59</b> , and that death occurred at <b>9:30</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>R. W. Prichard</b>		ADDRESS (Street, city or town, state) <b>715 Coiled Rd Glen Burnie, Md</b>	
PHYSICIAN'S NAME (Type) <b>R. W. PRICHARD M.D.</b>		DATE SIGNED <b>7/5/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar 9, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Allegheny Co. Mem. Pk.</b>		22d. LOCATION (City, town, or county) (State) <b>Pittsburgh, Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Richard V. Singleton</b>		ADDRESS <b>Glen Burnie, Md.</b>	
24a. REC'D BY REGISTRAR <b>MAR 9 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	

5

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G239 3-9-59 et

CERTIFICATE OF DEATH

02675

2630

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General</u>		d. STREET ADDRESS <u>1 805 Severn Ave.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>KATHERINE</u> Middle <u>M</u> Last <u>ROBERTS</u>		4. DATE OF DEATH Month <u>March</u> Day <u>1</u> Year <u>19 59</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 1, 1904</u>
9. AGE (In years last birthday) <u>54 yrs.</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>AUGUSTA HAUCK</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>                    </u>	
17. INFORMANT <u>CARROLL P ROBERTS</u>		Address <u>Husband- Same as #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ac. Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic C. V. Disease</u> DUE TO (c) <u>hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> <u>15 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 28</u> , 19 <u>59</u> , to <u>Mar 1</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Mar 1</u> , 19 <u>59</u> , and that death occurred at <u>2:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Maurice F Klawans</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>Annapolis, Md</u> <u>3/3/59</u>	
PHYSICIAN'S NAME (Type) <u>MAURICE F KLAWANS, MD</u>		<u>31 Southgate Ave, Annapolis, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>March 4, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOPPING FUNERAL HOME</u>		ADDRESS <u>Annapolis, Maryland</u>	
24a. REC'D BY REGISTRAR DATE <u>MAR 5 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Krawns</u>	



## CERTIFICATE OF DEATH

Reg. Dist. No.

02676

1. PLACE OF DEATH a. COUNTY <i>ANNE ARUNDEL</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>A.A. County</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>GLEN BURNIE</i>		c. LENGTH OF STAY IN 1b <i>3 yrs.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Forest Box 117 R.F.D. 5 Beechwood</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Le Roy E. Robinson</i>		4. DATE OF DEATH <i>MARCH 27, 1959</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 7, 1874</i>
9. AGE (In years lost birthday) <i>84 yrs.</i>		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Police MAN</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>BALTO. CITY</i>	11. BIRTHPLACE (State or foreign country) <i>MARYLAND. CALVERT CO.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>John Robinson</i>	
14. MOTHER'S MAIDEN NAME <i>Margaret V. Bordley</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>---</i>		17. INFORMANT <i>Mrs. Harry L. Meiser</i>	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <i>Arteriosclerotic Cardiovascular disease</i> DUE TO (c) <i>with Cardiac decompensation</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 days-</i> <i>3 years-</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Diabetes mellitus, 24 years duration</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Dec. 16, 1958</i> , to <i>March 27, 1959</i> , that I last saw the deceased alive on <i>March 25, 1959</i> , and that death occurred at <i>7:00 A.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>R.M. McLaughlin</i>		ADDRESS (Street, city or town, state) <i>REDS Box 442 Pasadena Md.</i>	
PHYSICIAN'S NAME (Type) <i>R.M. McLaughlin</i>		DATE SIGNED <i>March 27, 1959</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>MARCH 30-1959</i>	22c. NAME OF CEMETERY OR CREMATORY <i>London Park Cem.</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>G. Truman Schwal</i>		ADDRESS <i>3512 Frederick Ave. (29)</i>	
24a. REC'D BY REGISTRAR <i>MAR 30 59</i>		24b. REGISTRAR'S SIGNATURE <i>William S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH	
6. OCCUPATION		7. MARITAL STATUS		8. COLOR		9. RELIGION		10. EDUCATION	
11. PLACE OF DEATH		12. DATE OF DEATH		13. TIME OF DEATH		14. CAUSE OF DEATH		15. MANNER OF DEATH	
16. SIGNATURE OF PHYSICIAN		17. SIGNATURE OF WITNESS		18. SIGNATURE OF DECEASED		19. SIGNATURE OF FUNERAL HOME		20. SIGNATURE OF REGISTRAR	

1

THIS CERTIFICATE IS TO BE FILLED OUT BY THE PHYSICIAN OR OTHER PERSON HAVING KNOWLEDGE OF THE CAUSE OF DEATH. IT IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, WITHIN TEN DAYS OF THE DATE OF DEATH. A COPY OF THIS CERTIFICATE IS TO BE FURNISHED TO THE FUNERAL HOME AND TO THE NEAREST RELATIVE OF THE DECEASED.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02677

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

VS. A15ME  
SM 2/57

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. Anne Arundel Co. Gen.</u>		e. STREET ADDRESS <u>Benfield Rd</u>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>M. Saffield</u> Last <u>Benfield</u>		4. DATE OF DEATH Month <u>3</u> Day <u>23</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 18, 1881</u>
9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Guard</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>State of Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>A.A.Ct. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Richard Saffield</u>		14. MOTHER'S MAIDEN NAME <u>Mary Stevens</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>219-26-6741</u>	
17. INFORMANT <u>Lucy Saffield Benfield Rd. SevernaPar</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>782.4</u> DUE TO <u>Cardiac</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u> sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Chinua</u>		DATE SIGNED <u>3/23/59</u>	
EXAMINER'S NAME (Type) <u>E. J. Howard</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/26/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>	22d. LOCATION (City, town, or county) (State) <u>Ritchie Highway Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Schweinsberg Funeral Service</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 26 '59</u>	
ADDRESS <u>1126 W. Cross St. Balto. 30 Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

W. F. Schweinsberg





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2631

CERTIFICATE OF DEATH

02678

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>AA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. S. General Hospt</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Ellwood P. Scherger</u>				4. DATE OF DEATH Month <u>3</u> Day <u>15</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-27-1898</u>	
9. AGE (In years last birthday) <u>60</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY <u>Ret. Sheet Metal Worker Naval Academy</u>		11. BIRTHPLACE (State or foreign country) <u>Annapolis Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John H. Scherger</u>				14. MOTHER'S MAIDEN NAME <u>Magge Jacobs</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>World War I</u>		17. INFORMANT <u>Elizabeth C. Scherger</u>		Address <u>(2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Acute Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>3/15</u> , 19 <u>59</u> , to <u>3/15</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3/15</u> , 19 <u>59</u> , and that death occurred at <u>8:30</u> P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Richard N. Reeler</u>				ADDRESS (Street, city or town, state) <u>121 CATHEDRAL ST ANNAPOLIS, MD</u>			
DATE SIGNED <u>3/12/59</u>							
PHYSICIAN'S NAME (Type) <u>RICHARD N. REELER</u>				ADDRESS <u>ANNAPOLIS, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-18-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Annes Cemt</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Saylor Sues</u>				ADDRESS <u>Annapolis Md</u>		24a. REC'D BY REGISTRAR <u>MAR 19 59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## RYLAND STATE DEPARTMENT OF HEALTH—BETHLEHEM, PA.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

Items 8, 9, 14, Film G25711-10-59, E.J.

02679

2632

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.A. County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Ad Co</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Adenton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A.A. General</u>				d. STREET ADDRESS <u>PATYANT ROAD</u>			
3. NAME OF DECEASED (Type or print) <u>Franklin E. Sharp</u>				4. DATE OF DEATH <u>3 30 1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>January 8, 1959</u>		9. AGE (In years last birthday) <u>27</u> yrs.		IF UNDER 1 YEAR <u>27</u> Months <u>22</u> Days <u>22</u> Hours <u>22</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Annapolis, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank L. Sharp</u>				14. MOTHER'S MAIDEN NAME <u>Louise B. Russell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		INFORMANT <u>FRANK L. SHARP - Patyant Rd Adenton</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PERTUSSIS</u> <u>056.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>INTUSSUSCEPTION SIGMOID, WITH PERFORATION</u> DUE TO (c) <u>OF SIGMOID AND PERITONITIS</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 WKS</u> <u>10 DAYS</u> <u>2 DAYS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>20 Mar</u> , 19 <u>59</u> , to <u>30 Mar</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>30 March</u> , 19 <u>59</u> , and that death occurred at <u>10:00 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John F. Walker, M.D.</u>				ADDRESS (Street, city or town, state) <u>121 Cathedral St, Annapolis</u> DATE SIGNED <u>30 Mar 59</u>			
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/2/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Balto Nat'l Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. City MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. V. Singleton</u> ADDRESS <u>Shen Bunnie, Md.</u>				24a. REC'D BY REGISTRAR <u>APR 6 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

IN SENATE,  
January 10, 1901.  
REPORT  
OF THE  
COMMISSIONER OF THE  
LAND OFFICE,  
FOR THE YEAR  
1900.  
BY  
J. M. HARRIS,  
COMMISSIONER.  
DALLAS: THE TEXAS  
PRINTING CO., 1901.

2633

## CERTIFICATE OF DEATH

02680

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>AA</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md</i> b. COUNTY <i>AA</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>10 Annapolis</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>A. C. General</i>	d. STREET ADDRESS <i>115 Conduit</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Nora</i> Middle <i>F.</i> Last <i>Simmons</i>		4. DATE OF DEATH Month <i>3</i> - Day <i>9</i> Year <i>1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept 3-1907</i>
9. AGE (In years last birthday) yrs. <i>51</i>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	11. BIRTHPLACE (State or foreign country) <i>Benedict Md.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		13. FATHER'S NAME <i>Geo A. Springfield</i>	
14. MOTHER'S MAIDEN NAME <i>Anna Hurley</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <i>Yes</i>	
16. SOCIAL SECURITY NO.		17. INFORMANT <i>George A. Simmons</i> Address <i>(2)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>UR EMIA</i> <i>601X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>HYDRONEPHROSIS</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>72 HOURS</i> <i>UNKNOWN</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>HEPATITIS, INFECTIOUS</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>9/26, 1958</i> to <i>3/9, 1959</i> , that I last saw the deceased alive on <i>3/9, 1959</i> , and that death occurred at <i>730P</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Edward Sheek</i>		ADDRESS (Street, city or town, state) DATE SIGNED <i>41 Southgate AVE 3/11/59</i>	
PHYSICIAN'S NAME (Type) <i>ANNAPO/IS, MD</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>3-12-59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Hillcrest Cent</i>	22d. LOCATION (City, town, or county) (State) <i>Annapolis Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Saylor Sons</i>		24a. REC'D BY REGISTRAR <i>12 '59</i>	
ADDRESS <i>Annapolis Md</i>		24b. REGISTRAR'S SIGNATURE <i>Quito S. K.</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1903

<p>1. NAME OF DECEASED <i>John A. Smith</i></p>		<p>2. SEX <i>Male</i></p>	
<p>3. AGE <i>45</i></p>		<p>4. DATE OF BIRTH <i>Jan 15 1858</i></p>	
<p>5. PLACE OF BIRTH <i>Johns Hopkins</i></p>		<p>6. OCCUPATION <i>Teacher</i></p>	
<p>7. MARITAL STATUS <i>Married</i></p>		<p>8. DATE OF MARRIAGE <i>Jan 15 1880</i></p>	
<p>9. NAME OF SPOUSE <i>Johns Hopkins</i></p>		<p>10. DATE OF DEATH <i>Jan 15 1903</i></p>	
<p>11. PLACE OF DEATH <i>Johns Hopkins</i></p>		<p>12. CAUSE OF DEATH <i>Heart Disease</i></p>	
<p>13. MEDICAL HISTORY <i>None</i></p>		<p>14. SIGNATURE OF PHYSICIAN <i>Johns Hopkins</i></p>	
<p>15. SIGNATURE OF REGISTRAR <i>Johns Hopkins</i></p>		<p>16. SIGNATURE OF WITNESS <i>Johns Hopkins</i></p>	



## CERTIFICATE OF DEATH

Reg. Dist. No.

02681

2634

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marley (Glen Burnie P.O.)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Anne Arundel General Hospital</u>		d. STREET ADDRESS <u>201 - Marley Neck Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Florence</u> Middle <u>Ann</u> Last <u>Smith</u>		4. DATE OF DEATH Month <u>March</u> Day <u>12</u> Year <u>19 59</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 11, 1959</u>
9. AGE (In years last birthday) yrs. <u>17</u>		10. IF UNDER 1 YEAR Months Days Hours Min. <u>17 35</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Annapolis, Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>William Franklin Smith</u>		14. MOTHER'S MAIDEN NAME <u>Ruth Elaine Ross</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>None</u>	
INFORMANT <u>Mother</u>		Address <u>Marley Park, Glen Burnie, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> <u>776X</u> DUE TO <u>(Rubin's Caen.)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>17 hrs 35 min.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3/11</u> , 19 <u>59</u> to <u>3/12</u> , 19 <u>59</u> that I last saw the deceased alive on <u>March 12, 1959</u> , and that death occurred at <u>2:00 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Albert L. Anderson</u> M.D.		ADDRESS (Street, city or town, state) <u>44 Southgate Ave., Annapolis, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Albert L. Anderson</u>		DATE SIGNED <u>3/11/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>March 14, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>	22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. V. [Signature]</u>		ADDRESS <u>Glen Burnie, Md.</u>	24a. REC'D BY REGISTRAR <u>DATE MAR 16 '59</u>
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. [Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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2693

## CERTIFICATE OF DEATH

Reg. Dist. No.

02682

1. PLACE OF DEATH a. COUNTY <u>Cyrene Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>W.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Route 1 Box 436</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Viola</u> First <u>Stepney</u> Middle <u>Stepney</u> Last		4. DATE OF DEATH Month <u>3</u> Day <u>31</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-19-1894</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Millersville, Md.</u>	
13. FATHER'S NAME <u>Charles Hall</u>		14. MOTHER'S MAIDEN NAME <u>Martha Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no (or unknown)) <u>No</u> If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>770</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Arterio Sclerosis</u> 434.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Due to</u> (c) <u>Due to</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9-22-58</u> , 19 <u>58</u> , to <u>3-31-59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3-30-59</u> , 19 <u>59</u> , and that death occurred at <u>7:15</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>B. T. Allen</u>		DATE SIGNED <u>6-1-59</u>	
PHYSICIAN'S NAME (Type) <u>A. T. ALLEN</u>		ADDRESS (Street, city or town, state) <u>Annapolis, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-4-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>John Wesley</u>	22d. LOCATION (City, town, or county) (State) <u>Staterbury, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Geese, Jr.</u>		ADDRESS <u>Annapolis, Md.</u>	
24a. REC'D BY REGISTRAR <u>APR 3 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Clara J. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2694

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>A. A. Co.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>A. A. Co.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ordinance Rd. Curtis Bay</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Curtis Bay</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>Ordinance Road</b>	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>Stella</b> Middle <b>Hammond</b> Last <b>Stoll</b>		4. DATE OF DEATH Month <b>March</b> Day <b>20</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 2, 1879</b>
9. AGE (In years last birthday) <b>79</b>		IF UNDER 1 YEAR Months Days Hours Min.	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>A. A. Co. Md.</b>	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
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13. FATHER'S NAME <b>John T. Hammond</b>	14. MOTHER'S MAIDEN NAME <b>Camsadel Shipley</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT <b>Mrs. Dorothy S. Oxley</b>	Address <b>1004 Stewart Lane</b>	<b>Glen Burnie Md.</b>
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Thrombosis</b> <b>481X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Myocardial Failure</b> DUE TO <b>Influenza</b> (c)		INTERVAL BETWEEN ONSET AND DEATH
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from **3-14-1959** to **3-20-1959**, that I last saw the deceased alive on **3-14-1959**, and that death occurred at **12:45 PM**, from the causes and on the date stated above.

ACTUAL SIGNATURE <b>Louis J. Glass</b> M.D.	ADDRESS (Street, city or town, state) <b>320 Patapsco Ave.</b>	DATE SIGNED <b>3/20/59</b>
PHYSICIAN'S NAME (Type) <b>Louis J. Glass M.D.</b>		<b>320 Patapsco Ave.</b>

22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>March 23, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>	22d. LOCATION (City, town, or county) (State) <b>A. A. Co. Md.</b>
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23. FUNERAL DIRECTOR'S SIGNATURE <b>John O. Mitchell &amp; Sons Inc.</b>	ADDRESS <b>1900 Eutaw Place</b>	24a. REC'D BY REGISTRAR DATE <b>MAR 23 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director, and completely filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

02684

Reg. Dist. No.

2695

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>DORCHESTER</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CROWNSVILLE</b>		c. LENGTH OF STAY IN <b>1 month</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>CROWNSVILLE</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>IRVING</b> Middle <b>—</b> Last <b>THOMAS</b>		4. DATE OF DEATH Month <b>3</b> Day <b>14</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>N</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec 14, 1909</b>
9. AGE (In years last birthday) <b>49 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>rural</b>	
11. BIRTHPLACE (State or foreign country) <b>md USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles Thomas (dec)</b>		14. MOTHER'S MAIDEN NAME <b>Annie Thomas (dec)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>HOSPITAL RECORDS</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonitis</b> <b>223X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hemiplegia post surgical.</b> DUE TO (c) <b>Sub-dural Hygroma.</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>029X Syphilis - Decubitus Ulcers.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3/14/1959</b> to <b>3/13/1959</b> , that I last saw the deceased alive on <b>3/13/1959</b> and that death occurred at <b>9:15 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Lionel McHenry Mapp</b> M.D.		ADDRESS (Street, city or town, State) <b>Crownsville State Hospital</b> DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>Lionel McHenry Mapp, MD</b>		<b>Crownsville Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>MARCH 18, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>THOMPSON TOWN CEMETERY</b>	
22d. LOCATION (City, town, or county) (State) <b>NEAR EAST NEW MARKET, MD.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. J. Fraumpton &amp; Son, Federalburg, Md.</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>MAR 17 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2696

## CERTIFICATE OF DEATH

Reg. Dist. No.

02685

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b> c. LENGTH OF STAY IN 1b <b>1mo 7days</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Millersville</b> d. STREET ADDRESS <b>Route 1 - Box 26</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>James Ward</b>				4. DATE OF DEATH Month Day Year <b>3/12 19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 25, 1884</b>	
9. AGE (In years last birthday) <b>74 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>				10b. KIND OF BUSINESS OR INDUSTRY -----			
13. FATHER'S NAME <b>John Ward</b>				14. MOTHER'S MAIDEN NAME <b>Missouri</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-09-3102</b>		17. INFORMANT <b>Hospital Records</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypostatic Pneumonia</b> <b>023X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Aortic Insufficiency</b> DUE TO (c) <b>Syphilitic Cardiovascular Disease</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>000</b> p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	
20f. (City or town) -----				20g. (County) -----		20h. (State) -----	
21. I certify that I attended the deceased from <b>2/5</b> 19 <b>59</b> to <b>3/12</b> 19 <b>59</b> , that I last saw the deceased alive on <b>3/12</b> 19 <b>59</b> , and that death occurred at <b>6:35P.</b> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>L. Benedict M.D.</b>				ADDRESS (Street, city or town, state) <b>Crownsville State Hospital, Md.</b>			
DATE SIGNED <b>3/13/59</b>				DATE SIGNED <b>3/13/59</b>			
PHYSICIAN'S NAME (Type) <b>L. BENEDICT M.D.</b>				ADDRESS <b>Crownsville State Hospital, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/15/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>John Wesley</b>		22d. LOCATION (City, town, or county) (State) <b>Waterbury, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Geese, Jr. - Anna, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>MAR 16 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. Name of deceased: <u>JOHN J. BROWN</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Age: <u>45</u></p>		<p>4. Date of death: <u>10-15-1918</u></p>	
<p>5. Place of death: <u>Home</u></p>		<p>6. Cause of death: <u>Heart Disease</u></p>	
<p>7. Date of birth: <u>10-15-1873</u></p>		<p>8. Place of birth: <u>Massachusetts</u></p>	
<p>9. Occupation: <u>Engineer</u></p>		<p>10. Signature of physician: <u>[Signature]</u></p>	
<p>11. Signature of registrar: <u>[Signature]</u></p>		<p>12. Date of registration: <u>10-16-1918</u></p>	

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02686

2697

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b> c. LENGTH OF STAY IN 1b <b>8mo 11 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> c. STREET ADDRESS <b>619 N. Fremont Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>John Nathaniel Waters</b>				4. DATE OF DEATH Month <b>3</b> Day <b>4</b> Year <b>19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/6/92</b>	
9. AGE (In years last birthday) yrs. <b>66</b>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Receiving Freight</b>				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>John Waters</b>				14. MOTHER'S MAIDEN NAME <b>Georgianna</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <b>No</b>		16. SOCIAL SECURITY NO. <b>218-10-9883</b>		17. INFORMANT <b>Hospital Records</b> Address _____			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Post Surgical - Peptic Ulcer</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>002x Pulmonary Tuberculosis</b>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----
20c. TIME OF INJURY Month, Day, Year Hour <b>3</b> p. m. <b>19 59</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that I attended the deceased from <b>6/23</b> 19 <b>58</b> to <b>3/4</b> 19 <b>59</b> , that I last saw the deceased alive on <b>3/4</b> 19 <b>59</b> , and that death occurred at <b>9:45 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Crownsville State Hospital, Md.</b> DATE SIGNED <b>3/5/59</b>							
ACTUAL SIGNATURE <b>Lionel McHenry Mapp, M.D.</b>							
PHYSICIAN'S NAME (Type) <b>Lionel McHenry Mapp, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>		22b. DATE THEREOF <b>3/7/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Ignace</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles A. Rice</b>				ADDRESS <b>6616 Barre St</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 12 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanes</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

15

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

CERTIFICATE OF DEATH

Reg. No. 100

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

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**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**2635 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No.

**FOR STATE HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Mary Wells</b>	4. DATE OF DEATH Month <b>March</b> Day <b>16</b> Year <b>1959</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/5/05</b>
9. AGE (In years last birthday) <b>53</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>A.A.Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Wesley Brown</b>		14. MOTHER'S MAIDEN NAME <b>Annie Brown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>Robert Wells - Anna, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Syncope during anesthesia with pentothal and nitrous oxide.</b> 954X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DUE TO</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Russell S. Fisher</b>		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>3/17/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3-19-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Brewer Hill</b>	22d. LOCATION (City, town, or county) (State) <b>Annapolis, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Skilleam Reese, Jr. - Anna, Md.</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>MAR 18 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Harris</b>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
2803 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
John Doe		45		Male		White		1925		Home	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF BURIAL		DATE OF BURIAL	
123 Main St.		Teacher		Heart Disease		Natural		Cemetery		1925	
DATE OF EXAMINATION		TIME OF EXAMINATION		PLACE OF EXAMINATION		NAME OF EXAMINER		SIGNATURE OF EXAMINER		DATE OF EXAMINATION	
1925		10:00 AM		Home		Dr. Smith		[Signature]		1925	
DATE OF EXAMINATION		TIME OF EXAMINATION		PLACE OF EXAMINATION		NAME OF EXAMINER		SIGNATURE OF EXAMINER		DATE OF EXAMINATION	
1925		10:00 AM		Home		Dr. Smith		[Signature]		1925	

2698

CERTIFICATE OF DEATH

Reg. Dist. No.

02688

1. PLACE OF DEATH a. COUNTY <u>Anne Ar. County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>A.A.St. Md.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Orchard Beach Md.</u>		c. LENGTH OF STAY IN TB <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Rosalie</u> Middle <u>Wert</u> Last <u>Wert</u>		4. DATE OF DEATH Month <u>March</u> Day <u>26</u> Year <u>1959</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 2, 1884</u>
9. AGE (In years <u>74</u> <sup>last birthday</sup> yrs.)		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Wm. Hubbard</u>	
14. MOTHER'S MAIDEN NAME <u>Rose Fitzpatrick</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>none</u>	
16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Wallace Wert 7912 Seabreeze Dr.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> <u>447X</u> DUE TO <u>General Anasarca.</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>- Arterio Hypertension</u> (c) <u>-</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>6 mos</u> <u>- 6 mos</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 2</u> , 19 <u>28</u> , to <u>March 26</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>March 26</u> , 19 <u>59</u> , and that death occurred at <u>6:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. B. Mellett</u>		ADDRESS (Street, city or town, state) <u>1279 William St. Md.</u>	
PHYSICIAN'S NAME (Type) <u>W. B. MELLETT</u>		DATE SIGNED <u>3/28/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/30/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore</u>	22d. LOCATION (City, town, or county) (State) <u>End of North Ave. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Doris D. Krause</u>		ADDRESS <u>1216 S. Charles St.</u>	
24a. REC'D BY REGISTRAR <u>MAR 30 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2699

## CERTIFICATE OF DEATH

Reg. Dist. No.

02689

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b> c. LENGTH OF STAY IN 1b <b>1mo 5days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>407 N. Payson Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Louvenia</b> Middle <b>Williams</b> Last <b>Williams</b>		4. DATE OF DEATH Month <b>3</b> Day <b>10</b> Year <b>19 59</b>					
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1895</b>	9. AGE (In years last birthday) yrs. <b>63</b>	IF UNDER 1 YEAR Months <b>3</b> Days <b>10</b> Hours <b>19</b> Min. <b>59</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <b>Washington N.C.</b>			
13. FATHER'S NAME <b>Richard Herring</b>		14. MOTHER'S MAIDEN NAME <b>Rosie P</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Hospital Records</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Decompensation</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Aortic Insufficiency</b> DUE TO (c) <b>Syphilis</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Uremia and Anemia</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----					
20c. TIME OF INJURY Month, Day, Year Hour o. m. ----- p. m. ----- <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ----- 20f. (City or town) (County) (State) -----			
21. I certify that I attended the deceased from <b>2/5</b> , 19 <b>59</b> , to <b>3/10</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>3/10</b> , 19 <b>59</b> , and that death occurred at <b>5:00A.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Crownsville State Hospital, Md.</b> DATE SIGNED <b>3/10/59</b> ACTUAL SIGNATURE <b>Lionel McHenry Mapp, M. D.</b> PHYSICIAN'S NAME (Type) <b>Crownsville State Hospital, Md.</b> <b>3/10/59</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 14, 59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cem.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Mrs. Kate R. Williams</b>		ADDRESS <b>322 N. Schroeder St.</b>		24a. REC'D BY REGISTRAR <b>MAR 16 '59</b>			
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2700

## CERTIFICATE OF DEATH

Reg. Dist. No.

02690

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena Md 9 yrs</u>		c. LENGTH OF STAY IN 1b <u>False Waterford</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>False Waterford</u>		d. STREET ADDRESS <u>W Pasadena Md</u>	
3. NAME OF DECEASED (Type or print) <u>Raymond Napoleon Windsor</u>		4. DATE OF DEATH <u>March 9</u> 19 <u>59</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 29 1890</u>
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Coxswain</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Navy</u>	
11. BIRTHPLACE (State or foreign country) <u>Churchtown Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Windsor</u>		14. MOTHER'S MAIDEN NAME <u>Howe</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Navy 1st world war</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Wife Henrietta Windsor</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive C.V Disease</u> (c) <u>Gen. Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1955</u> , 19 <u>55</u> , to <u>1959</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3-7-59</u> , 19 <u>59</u> , and that death occurred at <u>11 A M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert R. Hahn</u>		ADDRESS (Street, city or town, state) <u>Severna Park 3-9-59</u>	
PHYSICIAN'S NAME (Type) <u>Robert R. Hahn</u>		DATE SIGNED <u>md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 12, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Lawson Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. J. Singleton</u>		ADDRESS <u>Ellen Bunnis, Md.</u>	
24a. REC'D BY REGISTRAR <u>MAR 12 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

0200

MARYLAND STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

2700

THE TWO  
A. B. D.  
M. B. O. N. I. D.



1. TO BE FILLED BY THE REGISTRAR OF DEATHS  
2. TO BE FILLED BY THE REGISTRAR OF DEATHS  
3. TO BE FILLED BY THE REGISTRAR OF DEATHS  
4. TO BE FILLED BY THE REGISTRAR OF DEATHS  
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9. TO BE FILLED BY THE REGISTRAR OF DEATHS  
10. TO BE FILLED BY THE REGISTRAR OF DEATHS

2636

## CERTIFICATE OF DEATH

Reg. Dist. No.

02691

1. PLACE OF DEATH o. COUNTY <i>Anne Arundel</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>				c. LENGTH OF STAY IN 1b <i>1 week</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Anne Arundel General Hospital</i>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Odenton</i>			
f. STREET ADDRESS <i>1st St.</i>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Charlie</i> Middle <i>E.</i> Last <i>YOUNG</i>				4. DATE OF DEATH Month <i>March</i> Day <i>2,</i> Year <i>19 59</i>			
5. SEX <i>MALE</i>		6. COLOR OR RACE <i>WHITE</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>23 Dec 58</i>	
9. AGE (In years last birthday) yrs. <i>2</i>		IF UNDER 1 YEAR Months <i>10</i> Days <i>10</i> Hours <i>10</i> Min. <i>10</i>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>infant</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Edward Young</i>				14. MOTHER'S MAIDEN NAME <i>ERVAAEE V. COLE</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT Address <i>Mother - SAME AS # 2</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac failure</i> <i>754.2</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Congenital intraventricular septal defect + pulmonary hypertension since birth</i> DUE TO (c) <i></i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Bilateral bronchopneumonia - congenital 'horseshoe' renal defect</i>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>23 Feb</i> , 19 <i>59</i> , to <i>2 MAR</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>2 MAR</i> , 19 <i>59</i> , and that death occurred at <i>9:15 P.M.</i> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <i>James I. Hudson, Jr.</i>				M.D. <i>RIVER CLUB ESTATES</i> <i>3 MAR 59</i>			
PHYSICIAN'S NAME (Type) <i>JAMES I. HUDSON, JR.</i>				EDGEWATER, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>March 5, 1959</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Hillcrest Memorial Corot</i>		22d. LOCATION (City, town, or county) (State) <i>Annapolis, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hopping Funeral Home</i> ADDRESS <i>Annapolis, Md.</i>				24a. REC'D BY REGISTRAR DATE <i>MAR 9 '59</i>			
				24b. REGISTRAR'S SIGNATURE <i>Charles S. H. H.</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02692

Reg. Dist. No.

2701

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Severn</b> c. LENGTH OF STAY IN 1b <b>2 weeks</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Same</b> b. COUNTY <b>Same</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Same</b>	
3. NAME OF DECEASED (Type or print) <b>Denise Dianne Young</b>		4. DATE OF DEATH <b>March 26th.</b> 19 <b>59</b>	
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/25/59</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Bowling Green, Kentucky.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Young</b>		14. MOTHER'S MAIDEN NAME <b>Ruth Taylor</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>17. INFORMANT</b> <b>Sergeant and Mrs. Wm. Young (parents)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Suffocation</b> <b>9240</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERNAL DISEASE ONSET AND COURSE <b>Sudden</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>Baby's face was in direct contact with the pillow.</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>Unknown</b> 19 <b>59</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> <b>Crib (Home)</b>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Severn, Md. A.A.</b>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Gustave H. Faubert, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Gustave H. Faubert, M.D.</b>		DATE SIGNED <b>3/26/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 29, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Fairview Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Bowling Green, Kentucky.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Richard T. Singleton</b>		24a. REC'D BY REGISTRAR <b>DATE MAR 30 '59</b>	
ADDRESS <b>Golden Breeze, Maryland</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

